Volume 37, Number 8
Pages 565–674
April 16, 2012

SALUS POPULI SUPREMA LEX ESTO

"The welfare of the people shall be the supreme law."

ROBIN CARNAHAN

SECRETARY OF STATE

MISSOURI REGISTER

The *Missouri Register* is published semi-monthly by

Secretary of State

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ISSN 0149-2942, USPS 320-630; periodical postage paid at Jefferson City, MO
Subscription fee: $56.00 per year

POSTMASTER: Send change of address notices and undelivered copies to:

MISSOURI REGISTER
Office of the Secretary of State
Administrative Rules Division
PO Box 1767
Jefferson City, MO 65102

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MISSOURI REGISTER

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Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please check out the website at http://www.sos.mo.gov/adrules/pubsched.asp

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HOW TO CITE RULES AND RSMo

RULES—Cite material in the *Missouri Register* by volume and page number, for example, Vol. 28, *Missouri Register*, page 27. The approved short form of citation is 28 MoReg 27.

The rules are codified in the *Code of State Regulations* in this system—

Title	***Code of State Regulations***	**Division**	**Chapter**	**Rule**
1	CSR	10-	1.	010
Department		Agency, Division	General area regulated	Specific area regulated

They are properly cited by using the full citation , i.e., 1 CSR 10-1.010.

Each department of state government is assigned a title. Each agency or division within the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraph 1., subparagraph A., part (I), subpart (a), item I. and subitem a.

RSMo—The most recent version of the statute containing the section number and the date.

The Secretary of State shall publish all executive orders beginning January 1, 2003, pursuant to section 536.035.2, RSMo Supp. 2011.

EXECUTIVE ORDER
12-05

WHEREAS, a State of Emergency was declared on April 22, 2011, pursuant to Executive Order 11-06 and extended by Executive Order 11-09, Executive Order 11-19, Executive Order 11-23 and Executive Order 11-25; and

WHEREAS, the tornadoes, floods and severe storms that have impacted the State have caused catastrophic damage and significant loss of life and continue to cause distress and hazards to citizens and communities; and

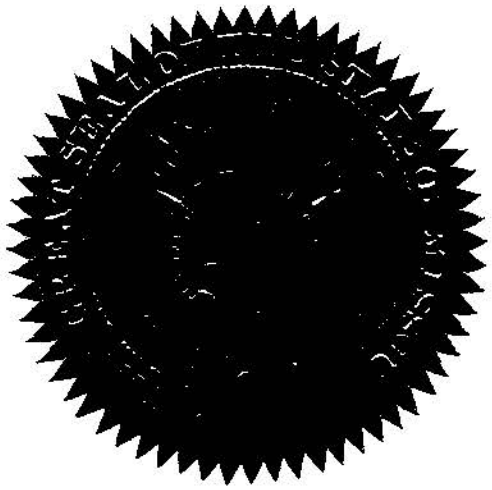
WHEREAS, the magnitude of recovery efforts exceeds the capabilities of local jurisdictions and other established agencies and necessitate the continued assistance of state emergency resources, including the Missouri National Guard; and

WHEREAS, on February 28-29, 2012, tornadoes and severe storms again impacted the State of Missouri causing significant damage and loss of life and required implementation of the Missouri State Emergency Operations Plan and activation of the Missouri National Guard; and

WHEREAS, several executive orders have been issued pursuant to the emergency powers contained in Chapter 44, RSMo, to aid in the response to these disasters and relieve the distress and hardship experienced by the affected citizens and communities.

NOW, THEREFORE, I, JEREMIAH W. (JAY) NIXON, GOVERNOR OF THE STATE OF MISSOURI, by the power vested in me by the Constitution and law of the State of Missouri, including Chapter 44, RSMo, do hereby extend the declaration of emergency contained in Executive Order 11-06 (as extended by Executive Orders 11-09, 11-19, 11-23 and 11-25) and Executive Order 12-03 until June 1, 2012 unless extended in whole or in part by subsequent order.

It is further ordered that Executive Order 11-07, Executive Order 11-11, Executive Order 11-14 and Executive Order 12-04 be extended until June 1, 2012 unless extended in whole or in part by subsequent order.



IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 13th day of March, 2012.

Jeremiah W. (Jay) Nixon
Governor

ATTEST:

Robin Carnahan
Secretary of State

Under this heading will appear the text of proposed rules and changes. The notice of proposed rulemaking is required to contain an explanation of any new rule or any change in an existing rule and the reasons therefor. This is set out in the Purpose section with each rule. Also required is a citation to the legal authority to make rules. This appears following the text of the rule, after the word "Authority."

Entirely new rules are printed without any special symbology under the heading of the proposed rule. If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission. Rules which are proposed to be amended will have new matter printed in boldface type and matter to be deleted placed in brackets.

An important function of the *Missouri Register* is to solicit and encourage public participation in the rulemaking process. The law provides that for every proposed rule, amendment, or rescission there must be a notice that anyone may comment on the proposed action. This comment may take different forms.

If an agency is required by statute to hold a public hearing before making any new rules, then a Notice of Public Hearing will appear following the text of the rule. Hearing dates must be at least thirty (30) days after publication of the notice in the *Missouri Register.* If no hearing is planned or required, the agency must give a Notice to Submit Comments. This allows anyone to file statements in support of or in opposition to the proposed action with the agency within a specified time, no less than thirty (30) days after publication of the notice in the *Missouri Register*.

An agency may hold a public hearing on a rule even though not required by law to hold one. If an agency allows comments to be received following the hearing date, the close of comments date will be used as the beginning day in the ninety (90)-day-count necessary for the filing of the order of rulemaking.

If an agency decides to hold a public hearing after planning not to, it must withdraw the earlier notice and file a new notice of proposed rulemaking and schedule a hearing for a date not less than thirty (30) days from the date of publication of the new notice.

Proposed Amendment Text Reminder:
Boldface text indicates new matter.
[Bracketed text indicates matter being deleted.]

Title 2—DEPARTMENT OF AGRICULTURE
Division 70—Plant Industries
Chapter 25—Pesticides

PROPOSED AMENDMENT

2 CSR 70-25.065 Acceptable Insurance and Bond Forms for Commercial Applicators. The director is amending subsections (1)(A), (B), and (C) and deleting the Editor's Note.

PURPOSE: This amendment changes commercial applicator insurance requirements to meet current Department of Insurance, Financial Institutions and Professional Registration requirements.

[Editor's Note: The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law.]

(1) Commercial applicators must use one (1) of the following methods for providing evidence of financial responsibility:

(A) Acceptable insurance or bond forms will be provided by the Bureau of Pesticide Control, Missouri Department of Agriculture, P*[.]*O*[.]* Box 630, Jefferson City, MO 65102. These forms must be completed and signed by an insurance company representative or a bonding agent. *[Acceptable certificates of insurance must affirm that the insured's policy meets the requirements of section 281.065, RSMo (1986).]* Acceptable bonds must have power of attorney, or authority to bind surety, attached;

(B) Certificates of insurance provided by insurance companies shall include:

1. Applicator's name, business name**,** and business address;
2. Policy number**;**
3. Effective and expiration dates;
4. Limits of liability; **and**
5. Insurance company representative's signature*[s]*; *[and]* **or**

[6. A signed statement from the insurance representative affirming that the insured's policy meets requirements of section 281.065, RSMo (Supp. 1988); or]

(C) Complete insurance policies which meet the requirements of section 281.065, RSMo *[(1986)]*.

*AUTHORITY: section 281.065, RSMo [Supp. 1989] **2000**. Original rule filed July 8, 1977, effective Oct. 14, 1977. Amended: Filed Aug. 14, 1989, effective Jan. 1, 1990. Amended: Filed March 8, 2012.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Agriculture, PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for 4:00 p.m, May 16, 2012, Missouri Department of Agriculture 2nd Floor Boardroom, 1616 Missouri Blvd., Jefferson City, Missouri.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 70—Plant Industries
Chapter 30—Feeds

PROPOSED AMENDMENT

2 CSR 70-30.110 Assessment of Administrative Penalties. The director is amending sections (1), (3), and (5), deleting section (4), and renumbering section (5).

PURPOSE: This amendment clarifies procedural requirements in the administrative penalty process.

(1) *[An]* **The director may assess an** administrative penalty, not to exceed one thousand dollars ($1,000) for each **serious** violation, *[can be assessed for serious violations by the director]* upon a *[violator]* **person** under authority of section 266.212, RSMo. An

order assessing the administrative penalty *[will]* **shall** state the statute under which the penalty is being sought, the manner of collection, and the right of appeal.

(3) *[Upon determination of a serious violation, an official compliance letter will be sent with—*

(A) A description of the serious violation;

(B) The suggested corrective action to be taken;

(C) A notice of the right to an informal hearing; and

(D) A notification that if the violation has not been corrected at the end of a ninety (90)-day compliance period, an order assessing an administrative penalty will be issued.] **Upon determination of a serious violation, an official compliance letter shall be sent to the person containing a description of the serious violation and a notification that if the violation has not been corrected within the ninety- (90-) day compliance period, an order assessing an administrative penalty may be issued.**

[(4) The official compliance letter will not be written until the following courses of action have been taken by the director:

(A) An official "Withdrawal from Distribution Order" has been sent, with description of the violation each time that the product(s) has failed to meet labeling guarantees;

(B) Warning letters will be sent to the labeler with an outline of the repeated failures of product(s) to meet labeling guarantees;

(C) A follow-up inspection will be made by the inspector if the labeler is within the state after each warning letter for an official sampling and label review to determine if the violating product is meeting labeling guarantees. If the labeler is out-of-state, telephone contact will be made after each warning letter to the violator;

(D) If cooperation is not obtained from the feed manufacturer, guarantor, or distributor to correct the violation(s) of labeling guarantees during the courses of action, as outlined in subsection (4)(A)–(C), the violation(s) will be classified as a "serious violation," and an official letter of compliance will be sent;

(E) The warning letters and follow-up inspections, as outlined in subsections (4)(A)–(D), will not be sent or made when a determination of adulteration or misbranding, within the meaning of sections 266.175 and 266.180, RSMo has been found to be hazardous to the health and well being of animals and/or humans. An official compliance letter will be sent and an investigation will be made immediately; and

(F) Warning letters and follow-up inspections, as outlined in subsections (4)(A)–(D), will not be sent or made when it is found that commercial feed has been knowingly removed, sold, or distributed while placed under a "Withdrawal from Distribution Order" by the director or an authorized representative. An official compliance letter will be sent immediately.]

*[(5)]***(4)** An administrative penalty, not to exceed one thousand ($1,000) dollars **per serious violation**, will be ordered by the director*[,]* based on*[—]* **the following factors:**

(A) *[Determination of t]***T**he level of adulteration or misbranding, within the meaning of sections 266.175 and 266.180, RSMo*[, and]*;

(B) *[t]***T**he degree of resulting physical injury, loss of health, or death to animals and/or humans; *[or]*

[(B) Determination of] **(C)** *[t]***T**he degree of *[the]* adverse economic impact to the purchaser caused by the violation; and/or

*[(C)]***(D)** The overall compliance record of the *[commercial feed labeler]* **person**.

*AUTHORITY: section 266.195, RSMo [Cum. Supp. 1997] **2000**. Original rule filed Nov. 17, 1997, effective June 30, 1998. Amended: Filed March 8, 2012.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Agriculture, PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 70—Plant Industries
Chapter 30—Feeds

PROPOSED AMENDMENT

2 CSR 70-30.115 Processed Animal Waste Products as Animal Feed Ingredients. The director is amending subsections (2)(A) and (B).

PURPOSE: This amendment corrects acid detergent fiber guarantee requirements and typographical errors.

(2) The following definitions apply to recycled animal waste products manufactured, labeled, and distributed only in the state of Missouri:

(A) Dried poultry waste, high ash—means a processed animal waste product composed primarily of feces from commercial poultry, which has been thermally dehydrated to a moisture content not in excess of fifteen percent (15%). It shall contain not less than eighteen percent (18%) crude protein, and not more than seventeen percent (17%) crude fiber, forty-five percent (45%) ash, and one percent (1%) feathers on a dry matter basis. Percentage guarantees for *[minimum]* **maximum** acid detergent fiber and maximum ash must be given on the feed label, plus feeding directions. The feeding directions *[must]* **shall** limit the inclusion of the animal waste to contributing not more than ten percent (10%) ash in the *[animals]* **animal's** final diet by weight on a dry matter basis. If total digestible nutrients (TDN) or calorie*[s]* contents are claimed, the factors for determining them must be those established by rule and such claims must be limited to the ingredient only; and

(B) Dried poultry litter, high ash—means a processed animal waste product composed of a processed combination of feces from commercial poultry together with litter that was present in the floor production of poultry, which has been dehydrated to a moisture content not in excess of fifteen percent (15%). It shall contain not less than eighteen percent (18%) crude protein, and not more than twenty-eight percent (28%) crude fiber, twenty-nine percent (29%) ash, and four percent (4%) feathers on a dry matter basis. Percentage guarantees for *[minimum]* **maximum** acid detergent fiber and maximum ash shall be given on the label, plus feeding directions. The feeding directions shall limit the inclusion of the animal waste to contributing not more than ten percent (10%) ash in the animal's final diet by weight on a dry matter basis. If TDN or calorie*[s]* contents are claimed, the factors for determining them must be those established by rule and such claims must be limited to the ingredient only.

*AUTHORITY: section 266.195, RSMo [Cum. Supp. 1997] **2000**. Original rule filed Nov. 17, 1997, effective June 30, 1998. Amended: Filed March 8, 2012.*

PUBLIC COST: This proposed amendment will not cost state agencies

or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Agriculture, PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 1—Organization and Description

PROPOSED AMENDMENT

2 CSR 80-1.010 General Organization. The board is amending sections (5) and (6).

PURPOSE: This proposed amendment is being updated to current location and phone number.

(5) The board is directed by section 196.939, RSMo *[(1986)]* **2000** to adopt regulations for the control of Grade A milk sanitation.

(6) The board is located at *[909]* **1616** Missouri Boulevard, Jefferson City, Missouri, telephone *[(314)]* **(573)** 751-3830. The board is assigned the responsibility for the administration of state milk inspection. State milk inspection is the service of inspection, regulation, grading**,** and program evaluation of fluid milk and fluid milk products.

AUTHORITY: section 196.939, RSMo [1986] ***2000****. Original rule filed April 5, 1976, effective Oct. 11, 1976. Amended: Filed March 13, 2012.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State Milk Board, 1616 Missouri Boulevard, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.020 Sale of Adulterated, Misbranded Milk, or Milk Products. The board is amending the purpose and section (2).

PURPOSE: This proposed amendment is being updated to correspond with the new ***Grade "A" Pasteurized Milk Ordinance*** *(PMO)—2011 Revision of the United States Department of Health and Human Services, Public Health Service, Food and Drug Administration.*

PURPOSE: This rule provides for the control of adulterated, misbranded Grade A milk or milk products, or any combination of these. This rule corresponds with [Part II,] Section 2 of the ***Grade "A" Pasteurized Milk Ordinance*** *[with Administrative Procedures—2009 Recommendations]* ***(PMO)—2011 Revision*** *of the* ***United States Department of Health and Human Services, Public Health Service/Food and Drug Administration*** *[(PMO)].*

(2) Any adulterated or misbranded milk or milk product may be impounded under proper authority by the regulatory agency and disposed of in accordance with applicable laws or regulations. The *[2009 edition of the]* Grade "A" Pasteurized Milk Ordinance *[with Administrative Procedures]* **(PMO), 2011 Revision** is hereby incorporated by reference as published by the **United States** Department of Health and Human Services, Public Health Service, Food and Drug Administration, *[Milk Safety Branch (HFS-626)]* **Division of Plant and Dairy Food Safety (HFS-316)**, 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009, effective Jan. 30, 2010. Amended: Filed March 13, 2012.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State Milk Board, 1616 Missouri Boulevard, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.030 Permits. The board is amending the purpose and section (5).

PURPOSE: This proposed amendment is being updated to correspond with the new ***Grade "A" Pasteurized Milk Ordinance*** *(PMO)—2011 Revision of the United States Department of Health and Human Services, Public Health Service, Food and Drug Administration.*

PURPOSE: This rule provides for the issuance of permits to persons involved in the production, transporting, and processing of Grade A milk and milk products. This rule corresponds with [Part II,] Section 3 of the ***Grade "A" Pasteurized Milk Ordinance*** *[with Administrative Procedures—2009 Recommendations]* ***(PMO), 2011 Revision*** *of the United States* ***Department of Health and Human Services,*** *Public Health Service/Food and Drug Administration [(PMO)].*

(5) Upon repeated violation(s), the regulatory agency may revoke the permit following reasonable notice to the permit holder and an opportunity for a hearing. This rule is not intended to preclude the institution of court action as provided in 2 CSR 80-2.050 (Section 5 of the PMO) and 2 CSR 80-2.060 (Section 6 of the PMO). The *[2009 edition of the] Grade "A" Pasteurized Milk Ordinance [with Administrative Procedures]* **(PMO), 2011 Revision** is hereby incorporated by reference as published by the **United States** Department of Health and Human Services, Public Health Service, Food and Drug Administration, *[Milk Safety Branch (HFS-626)]* **Division of Plant and Dairy Food Safety (HFS-316)**, 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009, effective Jan. 30, 2010. Amended: Filed March 13, 2012.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State Milk Board, 1616 Missouri Boulevard, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.040 Labeling. The board is amending the purpose and section (1).

PURPOSE: This proposed amendment is being updated to correspond with the new ***Grade "A" Pasteurized Milk Ordinance*** *(PMO)—2011 Revision of the United States Department of Health and Human Services, Public Health Service, Food and Drug Administration.*

PURPOSE: This rule provides regulations for the proper labeling of Grade A milk or milk products. This rule corresponds with [Part II,] Section 4 of the ***Grade "A" Pasteurized Milk Ordinance*** *[with Administrative Procedures—2009 Recommendations]* ***(PMO), 2011 Revision*** *of the United States* ***Department of Health and Human Services,*** *Public Health Service/Food and Drug Administration [(PMO)].*

(1) All bottles, containers, and packages enclosing milk or milk products defined in 2 CSR 80-2.010 (Section 1 of the PMO) of these rules shall be labeled in substantial compliance with the applicable requirements of the Federal Food, Drug and Cosmetic Act, the Fair Packaging and Labeling Act, and regulations developed thereunder and in addition shall comply with the applicable requirements of this rule as follows. The *[2009 edition of the] Grade "A" Pasteurized Milk Ordinance [with Administrative Procedures]* **(PMO), 2011 Revision** is hereby incorporated by reference as published by the **United States** Department of Health and Human Services, Public Health Service, Food and Drug Administration, *[Milk Safety Branch (HFS-626)]* **Division of Plant and Dairy Food Safety (HFS-316)**, 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009, effective Jan. 30, 2010. Amended: Filed March 13, 2012.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost the private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State Milk Board, 1616 Missouri Boulevard, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.050 Inspection Frequency and Procedure. The board is amending the purpose and section (4).

PURPOSE: This proposed amendment is being updated to correspond with the new ***Grade "A" Pasteurized Milk Ordinance*** *(PMO)—2011 Revision of the United States Department of Health and Human Services, Public Health Service, Food and Drug Administration.*

PURPOSE: This rule is for the purpose of providing requirements concerning inspection frequency and procedures. This rule corresponds with [Part II,] Section 5 of the ***Grade "A" Pasteurized Milk Ordinance*** *[with Administrative Procedures—2009 Recommendations]* ***(PMO), 2011 Revision*** *of the United States* ***Department of Health and Human Services,*** *Public Health Service/Food and Drug Administration [(PMO)].*

(4) It shall be unlawful for any person who, in an official capacity, obtains any information, which is entitled to protection as a trade secret (including information as to quantity, quality, source, or disposition of milk or milk products, or results of inspections or tests of milk or milk products), under the provisions of these rules, to use this information to his/her own advantage or to reveal it to any unauthorized person. The *[2009 edition of the] Grade "A" Pasteurized Milk Ordinance [with Administrative Procedures]* **(PMO), 2011 Revision** is hereby incorporated by reference as published by the **United States** Department of Health and Human Services, Public Health Service, Food and Drug Administration, *[Milk Safety Branch (HFS-626)]* **Division of Plant and Dairy Food (HFS-316)**, 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1,

1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009, effective Jan. 30, 2010. Amended: Filed March 13, 2012.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State Milk Board, 1616 Missouri Boulevard, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.060 The Examination of Milk and Milk Products. The board is amending the purpose and section (6).

PURPOSE: This proposed amendment is being updated to correspond with the new ***Grade "A" Pasteurized Milk Ordinance*** *(PMO)—2011 Revision of the United States Department of Health and Human Services, Public Health Service, Food and Drug Administration.*

PURPOSE: This rule specifies sampling frequency and required chemical and bacteriological tests to be conducted both on raw and pasteurized Grade A dairy products. This rule corresponds with [Part II,] Section 6 of the ***Grade "A" Pasteurized Milk Ordinance*** *[with Administrative Procedures—2009 Recommendations]* ***(PMO), 2011 Revision*** *of the United States* ***Department of Health and Human Services,*** *Public Health Service/Food and Drug Administration [(PMO)].*

(6) Samples shall be analyzed at an official or appropriate officially-designated laboratory. All sampling procedures and required laboratory examinations shall be in substantial compliance with the current edition of *Standard Methods for the Examination of Dairy Products of the American Public Health Association*, and the current edition of *Official Methods of Analysis of the Association of Official Analytical Chemists*. These procedures, including the certification of sample collectors and examinations shall be evaluated in accordance with *[2005]* **2011** *Evaluation of Milk Laboratories, Recommendations of the [U.S.]* ***United States Department of Human and Health Services,*** *Public Health Service/Food and Drug Administration*. Examinations and tests to detect adulterants, including pesticides, shall be conducted as the regulatory agency requires. Assays of milk and milk products to which vitamin(s) A, D, or both have been added, shall be made at least annually in a laboratory acceptable to the regulatory agency. The *[2009 edition of the] Grade "A" Pasteurized Milk Ordinance [with Administrative Procedures]* **(PMO), 2011 Revision** is hereby incorporated by reference as published by the **United States** Department of Health and Human Services, Public Health Service, Food and Drug Administration, *[Milk Safety Branch (HFS-626)]* **Division of Plant and Dairy Food (HFS-316)**, 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009, effective Jan. 30, 2010. Amended: Filed March 13, 2012.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State Milk Board, 1616 Missouri Boulevard, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.070 Standards for Milk and Milk Products. The board is amending the purpose and sections (1) and (2).

PURPOSE: This proposed amendment is being updated to correspond with the new ***Grade "A" Pasteurized Milk Ordinance*** *(PMO)—2011 Revision of the United States Department of Health and Human Services, Public Health Service, Food and Drug Administration.*

PURPOSE: This rule provides standards which Grade A raw or pasteurized milk or milk products must meet with regard to cooling temperatures, bacterial limits, somatic cell counts, antibiotics, coliform limits, phosphatase determinations, and sanitation requirements for dairy farms, milk haulers, transfer stations, receiving stations, and milk plants. This rule corresponds with [Part II,] Section 7 of the ***Grade "A" Pasteurized Milk Ordinance*** *[with Administrative Procedures—2009 Recommendations]* ***(PMO), 2011 Revision*** *of the United States* ***Department of Health and Human Services,*** *Public Health Service/Food and Drug Administration [(PMO)].*

(1) All Grade A raw milk for pasteurization and all Grade A pasteurized milk and milk products shall be produced, processed, and pasteurized to conform with the following chemical, bacteriological, and temperature standards and the sanitation requirements of this rule. The *[2009 edition of the] Grade "A" Pasteurized Milk Ordinance [with Administrative Procedures]* **(PMO), 2011 Revision** is hereby incorporated by reference as published by the **United States** Department of Health and Human Services, Public Health Service, Food and Drug Administration, *[Milk Safety Branch (HFS-626)]* **Division of Plant and Dairy Food (HFS-316)**, 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

(2) No process or manipulation other than pasteurization, processing methods integral to pasteurization, and appropriate refrigeration shall be applied to milk and milk products for the purpose of removing or deactivating microorganisms. Provided that in the bulk shipment of raw cream, skim milk, or lowfat milk, the heating of the raw milk to temperatures no greater than one hundred twenty-five degrees Fahrenheit (125 °F) **(fifty-two degrees Celsius** (52 °C)**)** for separation purposes is permitted when the resulting bulk shipments of cream, skim milk, and lowfat milk are labeled heat-treated.

Table 1—Chemical, Bacteriological, and Temperature Standards

Grade A raw milk for pasteurization	Temperature	Cooled to 45 °F (7 °C) or less within two (2) hours after milking, provided that the blend temperature first and subsequent milkings does not exceed 50 °F (10 °C).
	Bacterial limits	Individual producer milk not to exceed 100,000 per milliliter (ml) prior to commingling with other producer milk.
		Not to exceed 300,000 per ml as commingled milk prior to pasteurization.
	Antibiotics	Tests and methodology as required by the *[2009]* **2011** *Grade A Pasteurized Milk Ordinance.*
		Commingled milk: Tests and methodology as required by the *[2009]* **2011** *Grade A Pasteurized Milk Ordinanc*e.
	Somatic cell count	Individual producer milk: Not to exceed 750,000 per ml
Grade A pasteurized milk and milk products	Temperature	Cooled to 45 °F (7 °C) or less and maintained thereat.
	Bacterial limits*	20,000 per ml
	Coliform	Not to exceed 10 per ml: Provided that, in case of bulk milk transport tank shipments, shall not exceed 100 per ml
	Phosphatase	Less than one (1) microgram per ml by the Schrarer Rapid Method or Methods approved in the *[2009]* **2011** *[edition of the]* ***Grade "A"*** *Pasteurized Milk Ordinance*.
	Antibiotics	Test and methodology required by the *[2009]* **2011** *Grade "A" Pasteurized Milk Ordinance*.

*Not applicable to cultured products.

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009, effective Jan. 30, 2010. Amended: Filed March 13, 2012.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State Milk Board, 1616 Missouri Boulevard, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.080 Animal Health. The board is amending the purpose and section (3).

PURPOSE: This proposed amendment is being updated to correspond with the new ***Grade "A" Pasteurized Milk Ordinance*** *(PMO)—2011 Revision of the United States Department of Health and Human Services, Public Health Service, Food and Drug Administration.*

PURPOSE: This rule provides requirements regarding animal health for Grade A dairy farms. This rule corresponds with [Part II,] Section 8 of the ***Grade "A" Pasteurized Milk Ordinance*** *[with Administrative Procedures—2009 Recommendations]* ***(PMO), 2011 Revision*** *of the United States* ***Department of Health and Human Services,*** *Public Health Service/Food and Drug Administration [(PMO)].*

(3) For diseases other than brucellosis and tuberculosis, the regulatory agency shall require physical, chemical, or bacteriological tests as it deems necessary. The diagnosis of other diseases in dairy cattle shall be based upon the findings of a licensed veterinarian or a veterinarian in the employ of an official agency. Any diseased animal disclosed by these test(s) shall be disposed of as the regulatory agency directs. The *[2009 edition of the] Grade "A" Pasteurized Milk Ordinance [with Administrative Procedures]* **(PMO), 2011 Revision** is hereby incorporated by reference as published by the **United States** Department of Health and Human Services, Public Health Service, Food and Drug Administration, *[Milk Safety Branch (HFS-626)]* **Division of Plant and Dairy Food (HFS-316)**, 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009, effective Jan. 30, 2010. Amended: Filed March 13, 2012.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State Milk Board, 1616 Missouri Boulevard, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.091 Milk and Milk Products Which May Be Sold. The board is amending the purpose and section (1).

PURPOSE: This proposed amendment is being updated to correspond with the new ***Grade "A" Pasteurized Milk Ordinance*** *(PMO)—2011 Revision of the United States Department of Health and Human Services, Public Health Service, Food and Drug Administration.*

PURPOSE: This rule specifies milk and milk products which may be sold. This rule corresponds with [Part II,] Section 9 of the ***Grade "A" Pasteurized Milk Ordinance*** *[with Administrative Procedures—2009 Recommendations]* ***(PMO), 2011 Revision*** *of the United States* ***Department of Health and Human Services,*** *Public Health Service/Food and Drug Administration [(PMO)].*

(1) From and after the date on which this rule is adopted, except as provided by law (section 196.935, RSMo), only Grade A pasteurized milk and milk products shall be sold to the final consumer, or to restaurants, soda fountains, grocery stores, or similar establishments. Provided that in an emergency, the sale of pasteurized milk and milk products which have not been graded or the grade of which is unknown, may be authorized by the regulatory agency; in which case, the milk and milk products shall be labeled ungraded. The *[2009 edition of the] Grade "A" Pasteurized Milk Ordinance [with Administrative Procedures]* **(PMO), 2011 Revision** is hereby incorporated by reference as published by the **United States** Department of Health and Human Services, Public Health Service, Food and Drug Administration, *[Milk Safety Branch (HFS-626)]* **Division of Plant and Dairy Food (HFS-316)**, 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009, effective Jan. 30, 2010. Amended: Filed March 13, 2012.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State

*Milk Board, 1616 Missouri Boulevard, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.101 Transferring; Delivery Containers; Cooling. The board is amending the purpose and section (3).

*PURPOSE: This proposed amendment is being updated to correspond with the new **Grade "A" Pasteurized Milk Ordinance** (PMO)—2011 Revision of the United States Department of Health and Human Services, Public Health Service, Food and Drug Administration.*

*PURPOSE: This rule provides standards relating to transferring; delivery containers; and cooling of milk, milk products, or both. This rule corresponds with [Part II,] Section 10 of the **Grade "A" Pasteurized Milk Ordinance** [with Administrative Procedures—2009 Recommendations] **(PMO), 2011 Revision** of the United States **Department of Health and Human Service,** Public Health Service/Food and Drug Administration [(PMO)].*

(3) It shall be unlawful to sell or serve any pasteurized milk or milk products which have not been maintained at the temperature set forth in 2 CSR 80-2.070. If containers of pasteurized milk or milk products are stored in ice, the storage container shall be properly drained. The *[2009 edition of the] Grade "A" Pasteurized Milk Ordinance [with Administrative Procedures]* **(PMO), 2011 Revision** is hereby incorporated by reference as published by the **United States** Department of Health and Human Services, Public Health Service, Food and Drug Administration, *[Milk Safety Branch (HFS-626)]* **Division of Plant and Dairy Food (HFS-316)**, 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009, effective Jan. 30, 2010. Amended: Filed March 13, 2012.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State Milk Board, 1616 Missouri Boulevard, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.110 Milk and Milk Products from Points Beyond the Limits of Routine Inspection. The board is amending the purpose and section (1).

*PURPOSE: This proposed amendment is being updated to correspond with the new **Grade "A" Pasteurized Milk Ordinance** (PMO)—2011 Revision of the United States Department of Health and Human Services, Public Health Service, Food and Drug Administration.*

*PURPOSE: This rule provides for requirements for milk and milk products from points beyond the limits of routine inspection. This rule corresponds with [Part II,] Section 11 of the **Grade "A" Pasteurized Milk Ordinance** [with Administrative Procedures—2009 Recommendations] **(PMO), 2011 Revision** of the United States **Department of Health and Human Services,** Public Health Service/Food and Drug Administration [(PMO)].*

(1) Milk and milk products from points beyond the limits of routine inspection of the State Milk Board of Missouri or its jurisdiction may be sold in Missouri or its jurisdiction provided they are produced, pasteurized, or both, under rules which are substantially equivalent to the *Grade "A" Pasteurized Milk Ordinance [with Administrative Procedures—2009 Recommendations]* **(PMO), 2011 Revision** of the **United States Department of Health of Human Services,** *[U. S.]* Public Health Service/Food and Drug Administration and have been awarded an acceptable milk sanitation compliance and enforcement rating made by a state milk sanitation rating officer certified by the Food and Drug Administration. The *[2009 edition of the] Grade "A" Pasteurized Milk Ordinance [with Administrative Procedures]* **(PMO), 2011 Revision** is hereby incorporated by reference as published by the **United States** Department of Health and Human Services, Public Health Service, Food and Drug Administration, *[Milk Safety Branch (HFS-626)]* **Division of Plant and Dairy Food (HFS-316)**, 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009, effective Jan. 30, 2010. Amended: Filed March 13, 2012.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State Milk Board, 1616 Missouri Boulevard, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.121 Future Dairy Farms and Milk Plants. The board is amending the purpose and section (1).

*PURPOSE: This proposed amendment is being updated to correspond with the new **Grade "A" Pasteurized Milk Ordinance** (PMO)—2011 Revision of the United States Department of Health and Human Services, Public Health Service, Food and Drug Administration.*

*PURPOSE: This rule provides requirements for construction or reconstruction of future dairy farms and milk plants. This rule corresponds with [Part II,] Section 12 of the **Grade "A" Pasteurized Milk Ordinance** [with Administrative Procedures—2009 Recommendations] **(PMO), 2011 Revision** of the United States **Department of Health and Human Services,** Public Health Service/Food and Drug Administration [(PMO)].*

(1) Properly prepared plans shall be submitted to the regulatory agency for written approval before work is begun on all milkhouses, milking barns, stables and parlors, transfer stations, receiving stations, and milk plants regulated under these rules which are constructed, reconstructed, or extensively altered after July 1, 1980. The *[2009 edition of the] Grade "A" Pasteurized Milk Ordinance [with Administrative Procedures]* **(PMO), 2011 Revision** is hereby incorporated by reference as published by the **United States** Department of Health and Human Services, Public Health Service, Food and Drug Administration, *[Milk Safety Branch (HFS-626)]* **Division of Plant and Dairy Food (HFS-316)**, 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009, effective Jan. 30, 2010. Amended: Filed March 13, 2012.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State Milk Board, 1616 Missouri Boulevard, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.130 Personnel Health. The board is amending the purpose and section (1).

*PURPOSE: This proposed amendment is being updated to correspond with the new **Grade "A" Pasteurized Milk Ordinance** (PMO)—2011 Revision of the United States Department of Health and Human Services, Public Health Service, Food and Drug Administration.*

*PURPOSE: This rule establishes requirements relating to personnel health. This rule corresponds with [Part II,] Section 13 of the **Grade "A" Pasteurized Milk Ordinance** [with Administrative Procedures—2009 Recommendations] **(PMO), 2011 Revision** of the United States **Department of Health and Human Services,** Public Health Service/Food and Drug Administration [(PMO)].*

(1) No person affected with any disease in a communicable form, or while a carrier of that disease, shall work at any dairy farm or milk plant in any capacity which brings him/her into contact with the production, handling, storage, or transportation of milk, milk products, containers, equipment, and utensils; and no dairy farm or milk plant operator shall employ in any capacity any person or any person suspected of having any disease in a communicable form or of being a carrier of disease. Any producer or distributor of milk or milk products, upon whose dairy farm or in whose milk plant any communicable disease occurs, or who suspects that any employee has contracted any disease in a communicable form, or has become a carrier of the disease, shall notify the regulatory agency immediately. The *[2009 edition of the] Grade "A" Pasteurized Milk Ordinance [with Administrative Procedures]* **(PMO), 2011 Revision** is hereby incorporated by reference as published by the **United States** Department of Health and Human Services, Public Health Service, Food and Drug Administration, *[Milk Safety Branch (HFS-626)]* **Division of Plant and Dairy Food (HFS-316)**, 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009, effective Jan. 30, 2010. Amended: Filed March 13, 2012.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State Milk Board, 1616 Missouri Boulevard, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.141 Procedure When Infection is Suspected. The board is amending the purpose and subsection (1)(C).

*PURPOSE: This proposed amendment is being updated to correspond with the new **Grade "A" Pasteurized Milk Ordinance** (PMO)—2011 Revision of the United States Department of Health and Human Services, Public Health Service, Food and Drug Administration.*

*PURPOSE: This rule provides the procedure to follow when infection is suspected. This rule corresponds with [Part II,] Section 14 of the **Grade "A" Pasteurized Milk Ordinance** [with Administrative Procedures—2009 Recommendations] **(PMO), 2011 Revision** of the United States **Department of Health and Human Services,** Public Health Service/Food and Drug Administration [(PMO)].*

(1) When reasonable cause exists to suspect the possibility of transmission of infection from any person concerned with the handling of milk, milk products, or both, the regulatory agency is authorized to require any of the following measures:

(C) Adequate medical and bacteriological examination of the person, his/her associates, and of his/her and their body discharges. The *[2009 edition of the] Grade "A" Pasteurized Milk Ordinance*

[with Administrative Procedures] **(PMO), 2011 Revision** is hereby incorporated by reference as published by the **United States** Department of Health and Human Services, Public Health Service, Food and Drug Administration, *[Milk Safety Branch (HFS-626)]* **Division of Plant and Dairy Food (HFS-316)**, 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009, effective Jan. 30, 2010. Amended: Filed March 13, 2012.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State Milk Board, 1616 Missouri Boulevard, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.151 Enforcement. The board is amending the purpose and section (1).

PURPOSE: This proposed amendment is being updated to correspond with the new ***Grade "A" Pasteurized Milk Ordinance*** *(PMO)—2011 Revision of the United States Department of Health and Human Services, Public Health Service, Food and Drug Administration.*

PURPOSE: This rule provides for regulatory enforcement methods. This rule corresponds with [Part II,] Section 15 of the ***Grade "A" Pasteurized Milk Ordinance*** *[with Administrative Procedures—2009 Recommendations]* ***(PMO), 2011 Revision*** *of the United States* ***Department of Health and Human Services,*** *Public Health Service/Food and Drug Administration [(PMO)].*

(1) These rules shall be enforced by the regulatory agency in accordance with the *Grade A Pasteurized Milk Ordinance [with Administrative Procedures—Recommendations]* **(PMO), 2011 Revision** of the United States Public Health Service/Food and Drug Administration, a copy of which shall be on file at the State Milk Board office. Where the mandatory compliance with provisions of the appendices is specified, provisions shall be deemed a requirement of these rules. The *[2009 edition of the] Grade "A" Pasteurized Milk Ordinance [with Administrative Procedures]* **(PMO), 2011 Revision** is hereby incorporated by reference as published by the **United States** Department of Health and Human Services, Public Health Service, Food and Drug Administration, *[Milk Safety Branch (HFS-626)]* **Division of Plant and Dairy Food (HFS-316)**, 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009, effective Jan. 30, 2010. Amended: Filed March 13, 2012.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State Milk Board, 1616 Missouri Boulevard, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.161 Penalty. The board is amending the purpose and section (1).

PURPOSE: This proposed amendment is being updated to correspond with the new ***Grade "A" Pasteurized Milk Ordinance*** *(PMO)—2011 Revision of the United States Department of Health and Human Services, Public Health Service, Food and Drug Administration.*

PURPOSE: This rule provides for the penalty for violation of any of the provisions of these rules. This rule corresponds with [Part II,] Section 16 of the ***Grade "A" Pasteurized Milk Ordinance*** *[with Administrative Procedures—2009 Recommendations]* ***(PMO), 2011 Revision*** *of the United States* ***Department of Health and Human Services,*** *Public Health Service/Food and Drug Administration [(PMO)].*

(1) Any person(s) who shall violate any of the provisions of these rules shall be guilty of a misdemeanor and, upon conviction, shall be punished by a fine of not more than that established by the statutes of Missouri, or the person(s) may be enjoined from continuing the violations, or both. Each day upon which the violations occur shall constitute a separate violation. The *[2009 edition of the] Grade "A" Pasteurized Milk Ordinance [with Administrative Procedures]* **(PMO), 2011 Revision** is hereby incorporated by reference as published by the **United States** Department of Health and Human Services, Public Health Service, Food and Drug Administration, *[Milk Safety Branch (HFS-626)]* **Division of Plant and Dairy Food (HFS-316)**, 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009, effective Jan. 30, 2010. Amended: Filed March 13, 2012.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State Milk Board, 1616 Missouri Boulevard, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.170 Separability Clause. The board is amending the purpose and section (1).

*PURPOSE: This proposed amendment is being updated to correspond with the new **Grade "A" Pasteurized Milk Ordinance** (PMO)—2011 Revision of the United States Department of Health and Human Services, Public Health Service, Food and Drug Administration.*

*PURPOSE: This rule provides a separability clause. This rule corresponds with [Part II,] Section [17] **18** of the **Grade "A" Pasteurized Milk Ordinance** [with Administrative Procedures—2009 Recommendations] **(PMO), 2011 Revision** of the United States **Department of Health and Human Services,** Public Health Service/Food and Drug Administration [(PMO)].*

(1) Should any section, paragraph, sentence, clause, or phrase of these rules be declared unconstitutional or invalid for any reason, the remainder of these rules shall not be affected. The *[2009 edition of the] Grade "A" Pasteurized Milk Ordinance [with Administrative Procedures]* **(PMO), 2011 Revision** is hereby incorporated by reference as published by the **United States** Department of Health and Human Services, Public Health Service, Food and Drug Administration, *[Milk Safety Branch (HFS-626)]* **Division of Plant and Dairy Food (HFS-316)**, 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009, effective Jan. 30, 2010. Amended: Filed March 13, 2012.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State Milk Board, 1616 Missouri Boulevard, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.180 Adoption of the *Grade A Pasteurized Milk Ordinance* [with Administrative Procedures—Recommendations] (PMO), 2011 Revision of the United States Department of Health and Human Services, Public Health Service/Food and Drug Administration [(PMO)]. The board is amending the title of the rule, purpose, and section (1).

*PURPOSE: This proposed amendment is being updated to correspond with the new **Grade "A" Pasteurized Milk Ordinance** (PMO)—2011 Revision of the United States Department of Health and Human Services, Public Health Service, Food and Drug Administration.*

*PURPOSE: This rule provides for the adoption of the **Grade "A" Pasteurized Milk Ordinance** [with Administrative Procedures—Recommendations] **(PMO), 2011 Revision** of the United States **Department of Health and Human Services**, Public Health Service/Food and Drug Administration [(PMO)] which is the recommended ordinance for adoption by state and local governments for the sanitary control of Grade A milk and milk products.*

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) The *Grade "A" Pasteurized Milk Ordinance [with Administrative Procedures—Recommendations]* **(PMO), 2011 Revision** of the United States **Department of Health and Human Services,** Public Health Service/Food and Drug Administration *[(PMO)]* establishes minimum standards which must be complied with for satisfactorily producing and for processing Grade A raw milk for pasteurization and Grade A pasteurized milk and milk products in Missouri. The document further contains administrative procedures which provide information as to satisfactory compliance with the required items of sanitation. **The *Grade "A" Pasteurized Milk Ordinance* (PMO), 2011 Revision is hereby incorporated by reference as published by the United States Department of Health and Human Services, Public Health Service, Food and Drug Administration, Division of Plant and Dairy Food (HFS-316), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).**

*AUTHORITY: section 196.939, RSMo [1994] **2000**. Original rule filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Emergency amendment filed Oct. 25, 1999, effective Nov. 4, 1999, expired May 1, 2000. Amended: Filed Nov. 1, 1999, effective April 30, 2000. Amended: Filed March 13, 2012.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State Milk Board, 1616 Missouri Boulevard, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 4—Grade A Raw Milk for Pasteurization and Grade A Milk or Milk Products from Points Beyond the Limits of Routine Inspection

PROPOSED AMENDMENT

2 CSR 80-4.010 Rules for Import Milk. The board is amending section (1) and adding section (3).

*PURPOSE: This proposed amendment is being updated to correspond with the new **Grade "A" Pasteurized Milk Ordinance** (PMO)—2011 Revision of the United States Department of Health and Human*

Services, Public Health Service, Food and Drug Administration.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) The following regulations shall apply to section 196.949, RSMo *[(1986)]* **Supp. 2011** and *[all section 8 and 11 requirements of]* the *Grade "A" Pasteurized Milk Ordinance [with Administrative Procedures—1978 Recommendations]* **(PMO), 2011 Revision** of the *[U.S.]* **United States Department of Health and Human Services,** Public Health Service/Food and Drug Administration shall apply; except that in addition to these requirements, the following shall also apply:

(C) Fees established annually by the *[Missouri]* State Milk Board to cover the cost of sample collection and analysis along with administration of the program shall be paid on a monthly basis to the State Milk Board by the owner or manager of the milk source by the twentieth of each month for the preceding calendar month;

(D) All imported Grade A milk supplies shall be accepted in Missouri only after the source has been permitted *[jointly]* by the *[Missouri Division of Health, State Department of Agriculture and the]* State Milk Board*[;]* and **it's authorized representative; and**

(3) The *Grade "A" Pasteurized Milk Ordinance* (PMO), 2011 Revision is hereby incorporated by reference as published by the United States Department of Health and Human Services, Public Health Service, Food and Drug Administration, Division of Plant and Dairy Food (HFS-316), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

*AUTHORITY: section 196.949, RSMo [1986] **Supp. 2011**. Original rule filed May 3, 1976, effective Sept. 11, 1976. Amended: Filed Aug. 25, 1981, effective Jan. 14, 1982. Amended: Filed March 13, 2012.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State Milk Board, 1616 Missouri Boulevard, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 6—Wildlife Code: Sport Fishing: Seasons, Methods, Limits

PROPOSED AMENDMENT

3 CSR 10-6.415 Restricted Zones. The commission proposes to amend section (6) of this rule.

PURPOSE: This amendment clarifies ownership of areas where the use of shoes, boots, or waders with porous soles are prohibited.

(6) The use of shoes, boots, or waders with porous soles incorporating or having felt, matted, or woven fibrous materials is prohibited on the following *[department]* areas:

*AUTHORITY: sections 40 and 45 of Art. IV, Mo. Const. and section 252.240, RSMo 2000. Original rule filed June 13, 1994, effective Jan. 1, 1995. For intervening history, please consult the **Code of State Regulations**. Amended: Filed March 13, 2012.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Tom A. Draper, Deputy Director, Department of Conservation, PO Box 180, Jefferson City, MO 65102-0180. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 11—Wildlife Code: Special Regulations for Department Areas

PROPOSED AMENDMENT

3 CSR 10-11.120 Pets and Hunting Dogs. The commission proposes to delete paragraph (1)(A)5. and renumber subsequent paragraphs of this rule.

PURPOSE: This amendment eliminates the prohibition of pets and hunting dogs at Rockwoods Reservation.

(1) Pets and hunting dogs are permitted but must be on a leash or confined at all times, except as otherwise provided by signs, area brochures**,** or this chapter.

(A) Pets and hunting dogs are prohibited on the following department areas:

1. Burr Oak Woods Conservation Area;
2. Cape Girardeau Conservation Campus Nature Center;
3. Engelmann Woods Natural Area;
4. Powder Valley Conservation Nature Center;
[5. Rockwoods Reservation;]
*[6.]***5.** Runge Conservation Nature Center;
*[7.]***6.** Springfield Conservation Nature Center; and
*[8.]***7.** White Alloe Creek Conservation Area.

*AUTHORITY: sections 40 and 45 of Art. IV, Mo. Const. **and section 252.240, RSMo 2000.** This rule previously filed as 3 CSR 10-4.115. Original rule filed April 30, 2001, effective Sept. 30, 2001. For intervening history, please consult the **Code of State Regulations**. Amended: Filed March 13, 2012.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Tom A. Draper, Deputy Director, Department of Conservation, PO Box 180, Jefferson City, MO 65102-0180. To be considered, comments must be

*received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 11—Wildlife Code: Special Regulations for Department Areas

PROPOSED AMENDMENT

3 CSR 10-11.180 Hunting, General Provisions and Seasons. The commission proposes to add subsection (20)(B) and re-letter subsequent subsections of this rule.

PURPOSE: This amendment restricts hunting methods allowed at Horton Farm Conservation Area.

(20) Firearms firing single projectiles larger than twenty-two (.22) caliber rimfire are prohibited on the following areas:

(B) Horton Farm Conservation Area

*[(B)]***(C)** Montrose Conservation Area

*[(C)]***(D)** Guy B. Park Conservation Area

*[(D)]***(E)** Platte Falls Conservation Area

*AUTHORITY: sections 40 and 45 of Art. IV, Mo. Const. and section 252.240, RSMo 2000. This rule previously filed as 3 CSR 10-4.115. Original rule filed April 30, 2001, effective Sept. 30, 2001. For intervening history, please consult the **Code of State Regulations**. Amended: Filed March 13, 2012.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Tom A. Draper, Deputy Director, Department of Conservation, PO Box 180, Jefferson City, MO 65102-0180. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 12—Wildlife Code: Special Regulations for Areas Owned by Other Entities

PROPOSED AMENDMENT

3 CSR 10-12.109 Closed Hours. The commission proposes to delete subsections (1)(E), (1)(F), and (1)(H); add subsections (1)(D), (1)(E), and (1)(K); and re-letter subsequent subsections of this rule.

PURPOSE: This amendment removes Higbee (City Waterworks Lake) from the list of areas closed from 10:00 p.m. to 4:00 a.m. daily for certain uses and adds Cameron Reservoirs Nos. 1, 2, and 3 to the list. An ordering issue is also corrected.

(1) Closed Hours. The following areas are closed to public use from 10:00 p.m. to 4:00 a.m. daily; however, hunting, fishing, trapping, dog training, camping, launching boats, and landing boats are permitted at any time on areas where these activities are authorized, except as further restricted in this chapter.

(D) Cameron (Reservoirs Nos. 1, 2, and 3, and Grindstone Reservoir)

(E) Department of Mental Health (Marshall Habilitation Center Lake)

*[(D)]***(F)** Empire District Electric Company (Ozark Beach Recreation Area)

[(E) Department of Mental Health (Marshall Habilitation Center Lake)]

[(F) Liberty (Fountain Bluff Park Ponds Nos. 1, 2, 3, 4, 5, 6, 7, and 8)]

[(H) Higbee (City Waterworks Lake)]

*[(I)]***(H)** Kirksville (Hazel Creek Lake, Spur Pond)

*[(J)]***(I)** Lancaster (City Lake, Paul Bloch Memorial Pond)

*[(K)]***(J)** LaPlata City Lake

(K) Liberty (Fountain Bluff Park Ponds Nos. 1, 2, 3, 4, 5, 6, 7, and 8)

*AUTHORITY: sections 40 and 45 of Art. IV, Mo. Const. and section 252.240, RSMo 2000. Original rule filed June 1, 2001, effective Oct. 30, 2001. For intervening history, please consult the **Code of State Regulations**. Amended: Filed March 13, 2012.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Tom A. Draper, Deputy Director, Department of Conservation, PO Box 180, Jefferson City, MO 65102-0180. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 12—Wildlife Code: Special Regulations for Areas Owned by Other Entities

PROPOSED AMENDMENT

3 CSR 10-12.110 Use of Boats and Motors. The commission proposes to amend section (5), delete subsections (5)(A) and (B), re-letter the remaining subsection, add subsection (6)(A), and re-letter subsequent subsections of this rule.

PURPOSE: This amendment removes Bethany (North Bethany City Reservoir) and Fayette (D.C. Rogers Lake, Peters Lake) from the list of areas where outboard motors not in excess of ten (10) horsepower may be used and adds Bethany (North Bethany City Reservoir) to the list of areas where outboard motors in excess of ten (10) horsepower may be used but must be operated at slow, no-wake speed.

(5) Outboard motors not in excess of ten (10) horsepower may be used on the following area[*s*]:

[(A) Bethany (North Bethany City Reservoir)]

[(B) Fayette (D.C. Rogers Lake, Peters Lake)]

*[(C)]***(A)** Springfield City Utilities (Lake Springfield)

(6) Outboard motors in excess of ten (10) horsepower may be used but must be operated at slow, no-wake speed on the following areas:

(A) Bethany (North Bethany City Reservoir)

*[(A)]***(B)** Brookfield City Lake

*[(B)]***(C)** Cameron (Grindstone Reservoir)

*[(C)]***(D)** Fayette (D.C. Rogers Lake, Peters Lake)

*[(D)]***(E)** Fredericktown City Lake

*[(E)]***(F)** Green City Lake
*[(F)]***(G)** Little River Drainage District (Headwaters Diversion Channel)
*[(G)]***(H)** Higginsville City Lake
*[(H)]***(I)** Holden City Lake
*[(I)]***(J)** Iron Mountain City Lake
*[(J)]***(K)** La Plata City Lake
*[(K)]***(L)** Macon City Lake
*[(L)]***(M)** Marceline (Marceline City Lake, Old Marceline City Reservoir)
*[(M)]***(N)** Mark Twain National Forest (Council Bluff Lake, Palmer Lake)
*[(N)]***(O)** Maysville (Willow Brook Lake)
*[(O)]***(P)** Memphis (Lake Showme)
*[(P)]***(Q)** Milan (Elmwood Lake)
*[(Q)]***(R)** Moberly (Rothwell Park Lake, Sugar Creek Lake, and Water Works Lake)
*[(R)]***(S)** Monroe City (Route J Reservoir)
*[(S)]***(T)** Unionville (Lake Mahoney)
*[(T)]***(U)** Wakonda State Park (Agate Lake and Wakonda Lake)
*[(U)]***(V)** Watkins Woolen Mill State Park and Historic Site (Williams Creek Lake)

AUTHORITY: sections 40 and 45 of Art. IV, Mo. Const. and section 252.240, RSMo 2000. This rule previously filed as 3 CSR 10-4.116. Original rule filed April 30, 2001, effective Sept. 30, 2001. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed March 13, 2012.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Tom A. Draper, Deputy Director, Department of Conservation, PO Box 180, Jefferson City, MO 65102-0180. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 12—Wildlife Code: Special Regulations for Areas Owned by Other Entities

PROPOSED AMENDMENT

3 CSR 10-12.125 Hunting and Trapping. The commission proposes to delete paragraph (1)(B)16. and renumber subsequent paragraphs of this rule.

PURPOSE: This amendment removes Jamesport City Lake from the this rule.

(1) Hunting, under statewide permits, seasons, methods, and limits, is permitted except as further restricted in this chapter and except for deer and turkey hunting as authorized in the annual *Fall Deer & Turkey Hunting Regulations and Information* booklet published in August and annual *Spring Turkey Hunting Regulations and Information* booklet published in March, which are incorporated in this *Code* by reference. A printed copy of these booklets can be obtained from the Missouri Department of Conservation, PO Box 180, Jefferson City, MO 65102-0180 and are also available online at www.missouriconservation.org. This rule does not incorporate any subsequent amendments or additions.

(B) Hunting is prohibited on the following areas:

1. Thomas S. Baskett Wildlife Research and Education Center;
2. Bethany (Old Bethany City Reservoir);
3. Buchanan County (Gasper Landing);
4. California (Proctor Park Lake);
5. Carthage (Kellogg Lake);
6. Columbia (Antimi Lake, Cosmo-Bethel Lake, Lake of the Woods, Twin Lake);
7. Dexter City Lake;
8. Farmington (Giessing Lake, Hager Lake, Thomas Lake);
9. Fenton (Preslar Lake, Upper Fabick Lake, Westside Lake);
10. Fulton (Morningside Lake, Truman Lake, Veterans Park Lake);
11. Hamilton City Lake;
12. Harrisonville (North Lake);
13. Jackson (Rotary Lake);
14. Jackson County (Alex George Lake, Bergan Lake, Bowlin Road Pond, Fleming Pond, Lake Jacomo, Prairie Lee Lake, Scherer Lake, Tarsney Lake, Wood Lake, Wyatt Lake);
15. James Foundation (Scioto Lake);
[16. Jamesport City Lake;]
*[17.]***16.** Kirksville (Spur Pond);
*[18.]***17.** Lawson City Lake;
*[19.]***18.** Liberty (Fountain Bluff Park Ponds Nos. 1, 2, 3, 4, 5, 6, 7, and 8);
*[20.]***19.** Macon County (Fairgrounds Lake);
*[21.]***20.** Mexico (Lakeview Lake, Kiwanis Lake);
*[22.]***21.** Mineral Area College (Quarry Pond);
*[23.]***22.** Moberly (Rothwell Park Lake, Water Works Lake);
*[24.]***23.** Mount Vernon (Williams Creek Park Lake);
*[25.]***24.** Odessa (Lake Venita);
*[26.]***25.** Overland (Wild Acres Park Lake);
*[27.]***26.** Potosi (Roger Bilderback Lake);
*[28.]***27.** Rolla (Schuman Park Lake);
*[29.]***28.** St. Charles (Fountain Lakes Pond, Kluesner Lake, Moore Lake, Skate Park Lake);
*[30.]***29.** St. Louis County (Bee Tree Park Lake, Blackjack Lake, Carp Lake, Creve Coeur Park Lake, Fountain Lake, Island Lake, Jarville Lake, Simpson Park Lake, Spanish Lake, Sunfish Lake);
*[31.]***30.** Savannah City Lake;
*[32.]***31.** Sedalia (Clover Dell Park Lake);
*[33.]***32.** Sedalia Water Department (Spring Fork Lake);
*[34.]***33.** Springfield City Utilities (Lake Springfield);
*[35.]***34.** Warrensburg (Lions Lake);
*[36.]***35.** Watershed Committee of the Ozarks (Valley Water Mill Lake); and
*[37.]***36.** Windsor (Farrington Park Lake).

AUTHORITY: sections 40 and 45 of Art. IV, Mo. Const. and section 252.240, RSMo 2000. This rule previously filed as 3 CSR 10-4.116. Original rule filed April 30, 2001, effective Sept. 30, 2001. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed March 13, 2012.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Tom A. Draper, Deputy Director, Department of Conservation, PO Box 180, Jefferson City, MO 65102-0180. To be considered, comments must be

received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 85—Intermediate Care and Skilled Nursing Facility

PROPOSED AMENDMENT

19 CSR 30-85.022 Fire Safety ***and Emergency Preparedness*** **Standards for New and Existing Intermediate Care and Skilled Nursing Facilities**. The department is amending the title of the rule, the purpose statement, the second publisher's note, sections (1), (5), (8), (10), (11), (13), (21), (33), (39), (40), and (41); deleting section (12); adding new section (14); and renumbering sections (13) and (14).

PURPOSE: This amendment adds emergency preparedness requirements, updates and clarifies fire alarm system and sprinkler system requirements, and removes redundancy and archaic language.

PURPOSE: This rule establishes fire-safety ***and emergency preparedness*** *requirements for new and existing intermediate care and skilled nursing facilities.*

[PUBLISHER'S] ***AGENCY*** *NOTE: All rules relating to long-term care facilities licensed by the [Division of Aging]* ***Department of Health and Senior Services*** *are followed by a Roman Numeral notation which refers to the class (either class I, II, or III) of standard as designated in section 198.085[.1], RSMo [1994]* ***2000****.*

(1) Definitions. For the purpose of this rule, the following definitions shall apply:

(A) Accessible spaces—shall include all rooms, halls, storage areas, basements, attics, lofts, closets, elevator shafts, enclosed stairways, dumbwaiter shafts, and chutes;

(B) Area of refuge—a space located in or immediately adjacent to a path of travel leading to an exit that is protected from the effects of fire, either by means of separation from other spaces in the same building or its location, permitting a delay in evacuation. An area of refuge may be temporarily used as a staging area that provides some relative safety to its occupants while potential emergencies are assessed, decisions are made, and if applicable, evacuation has begun; *[and]*

(C) Major renovation—shall include the following:

1. Addition of any room(s), accessible by residents, that either exceeds fifty percent (50%) of the total square footage of the facility or exceeds four thousand five hundred (4,500) square feet; *[or]*

2. Repairs, remodeling, or renovations that involve more than fifty percent (50%) of the building; *[or]*

3. Repairs, remodeling, or renovations that involve more than four thousand five hundred (4,500) square feet of a smoke section*[.]***; or**

4. If the addition is separated by two- (2-)*[-]* hour fire-resistant construction, only the addition portion shall meet the requirements for an NFPA 13, 1999 edition, sprinkler system, unless the facility is otherwise required to meet NFPA 13, 1999 edition*[.]***; and**

(D) Concealed spaces—shall include areas within the building that cannot be occupied or used for storage.

(5) The *[department prohibits the]* storage of any unnecessary combustible materials in any part of a building in which a licensed facility is located **is prohibited**. No section of the building shall present a fire hazard. I/II

(8) Fire Extinguishers.

(D) All fire extinguishers shall bear the label of the *[Underwriters' Laboratories ([]*UL*[])]* or the *[Factory Mutual ([]*FM*[])]* Laboratories and shall be installed and maintained in accordance with NFPA 10, 1998 edition. This includes the documentation and dating of a monthly pressure check. II/III

(10) Complete Fire Alarm Systems.

(A) Facilities shall have a complete fire alarm system installed in accordance with NFPA 101, Section 18.3.4, 2000 edition. The complete fire alarm system shall automatically transmit to the fire department, dispatching agency, or central monitoring company. The complete fire alarm system shall include visual signals and audible alarms that can be heard throughout the building and a main panel that interconnects all alarm-activating devices and audible signals in accordance with NFPA 72, 1999 edition. *[At a minimum, the complete fire alarm system shall consist of m]***M**anual pull stations **shall be installed** at or near each **required nurse**/attendant's station and each required exit**.** *[and s]***S**moke detectors **shall be** interconnected to the complete fire alarm system. Specific minimum requirements relating to the interconnected smoke detectors are found in subsections (10)(I) and (10)(J) of this rule. I/II

(G) Upon discovery of a fault with the complete fire alarm system, the facility shall *[promptly]* correct the fault. I/II

(I) *[Facilities that have a sprinkler system in accordance with NFPA 13, 1999 edition,]* **All facilities** shall have smoke detectors interconnected to the complete fire alarm system in all corridors and spaces open to *[the]* corridor**s**. Smoke detectors shall be no more than thirty feet (30') apart with no point on the ceiling more than twenty-one feet (21') from a smoke detector. I/II

(J) Facilities that *[do not have a sprinkler system in accordance with NFPA 13, 1999 edition,]* **have a sprinkler system exemption** shall have smoke detectors interconnected to the complete fire alarm system in all accessible spaces within the facility as required by NFPA 72, 1999 edition. Smoke detectors shall be no more than thirty feet (30') apart with no point on the ceiling more than twenty-one feet (21') from a smoke detector. Smoke detectors shall not be installed in areas where environmental influences may cause nuisance alarms. Such areas include, but are not limited to, kitchens, laundries, bathrooms, mechanical air handling rooms, and attic spaces. In these areas, heat detectors interconnected to the complete fire alarm system shall be installed. Bathrooms not exceeding fifty-five (55) square feet and clothes closets, linen closets, and pantries not exceeding twenty-four (24) square feet are exempt from having any detection device if the walls and ceilings are surfaced with limited-combustible or noncombustible material as defined in NFPA 101, 2000 edition. Concealed spaces of noncombustible or limited-combustible construction are not required to have detection devices. These spaces may have limited access but cannot be occupied or used for storage. I/II

(K) For each facility not having a sprinkler system exemption, each resident room or any room designated for sleeping shall be equipped with at least one (1) battery-powered smoke alarm installed, tested, and maintained in accordance with manufacturer's specifications. In addition, the facility shall be equipped with interconnected heat detectors installed, tested, and maintained in accordance with NFPA 72, 1999 edition, with detectors in all areas subject to nuisance alarms, including, but not limited to, kitchens, laundries, bathrooms, mechanical air handling rooms, and attic spaces. I/II

1. The facility shall maintain a written record of the monthly testing and battery changes. The written records shall be retained for one (1) year. I/II

2. Upon discovery of a fault with any detector or alarm, the facility shall correct the fault. I/II

(11) Sprinkler System.

(B) All facilities licensed prior to August 28, 2007, that *[do not]*

were not required to have a complete sprinkler system in accordance with NFPA 13 shall have until December 31, 2012, to comply with NFPA 13, 1999 edition. I/II *[Exceptions shall be granted to this requirement if the following conditions are met:]*

1. *[The water supply for an NFPA 13 sprinkler system is unavailable, and the department receives a statement in writing from a licensed engineer or a certified sprinkler representative documenting the unavailability of water; or]* **Exemptions shall be granted if the facility presents evidence in writing from a certified sprinkler system representative or licensed engineer that the facility is unable to install an approved NFPA 13, 1999 edition, system due to the unavailability of the water supply. I/II**

[2. The facility meets Chapter 33 of NFPA 101, Life Safety Code, 2000 edition, and the evacuation capability of residents meets the standards in NFPA 101A, Guide to Alternative Approaches to Life Safety, 2001 edition. I/II]

(C) Facilities that have sprinkler systems installed prior to August 28, 2007, shall inspect, maintain, and test these systems in accordance with *[NFPA 13, 1999 edition, and NFPA 25, 1998 edition]* **the requirements in effect for such facilities licensed on August 27, 2007**. I/II

(D) Facilities licensed on or after August 28, 2007, or any **section of a** facility *[performing]* **in which a** major renovation*[s to the facility]* **has been completed on or after August 28, 2007**, shall *[have]* **install and maintain** a complete sprinkler system *[installed]* in accordance with NFPA 13, 1999 edition. I/II

(E) When a sprinkler system is to be out-of-service for more than four (4) hours in a twenty-four**-** (24-)*[-]* hour period, the facility shall immediately notify the department and the local fire authority and implement an approved fire watch in accordance with NFPA 101, 2000 edition, until the sprinkler system has returned to full service. I/II

[(12) All facilities shall submit, by July 1, 2008, a plan for compliance to the state fire marshal showing how the facility meets the requirements of sections (10), (11), (28), and (29) of this rule. If the facility's plan for compliance does not meet the requirements of sections (10), (11), (28), and (29) of this rule, the facility shall provide the state fire marshal with a written plan to include, at a minimum, an explanation of how the requirements of sections (10), (11), (28), and (29) will be met, when they will be met, and contact information in the event the plan does not evidence compliance with these requirements. II

(A) To qualify for a sprinkler system exception, the facility shall present evidence to the state fire marshal in writing from a certified sprinkler system representative or licensed engineer that the facility is unable to install an approved National Fire Protection Association 13 system due to the unavailability of water supply requirements associated with this system or the facility meets the safety requirements of Chapter 33 of existing residential board and care occupancies of NFPA 101, Life Safety Code. II]

*[(13)]***(12)** Each floor of an existing licensed facility shall have at least two (2) unobstructed exits remote from each other. One (1) of the required exits in an existing multi-story facility must be an outside stairway or an enclosed stair that is separated by one**-** (1-)*[-]* hour construction from each floor and has an exit leading directly outside at grade level. One (1) exit may lead to a lobby with exit facilities to the ground level outside instead of leading directly to the outside. The lobby shall have at least a one**-** (1-)*[-]* hour fire-rated separation from the remainder of the exiting floor. I/II

*[(14)]***(13)** If facilities have outside stairways, they shall be substantially constructed to support residents during evacuation. These stairways shall be protected or cleared of ice and snow. *[Fire escapes added to existing buildings, whether interior or exterior, shall have at least a minimum thirty-six-inch (36") width, eight-inch (8") maximum risers, a nine-inch (9") minimum tread, no winders, a maximum height between landings of twelve feet (12'), minimum landing dimensions of forty-four inches (44"), landings at each exit door, and handrails on both sides.]* Stairways shall be of sturdy construction using at least two-inch (2") lumber and shall be continuous to ground level. *[Exit(s) to fire escapes shall be at least thirty-six inches (36") wide, and the fire-escape door shall swing outward.]* All treads and risers shall be of the same height and width throughout the entire stairway, not including landings. II/III

(14) Fire escapes added to existing buildings, whether interior or exterior, shall have at least a minimum thirty-six-inch (36") width, eight-inch (8") maximum risers, a nine-inch (9") minimum tread, no winders, a maximum height between landings of twelve feet (12'), minimum landing dimensions of forty-four inches (44"), landings at each exit door, and handrails on both sides. Exit(s) to fire escapes shall be at least thirty-six inches (36") wide, and the fire-escape door shall swing outward. All treads and risers shall be of the same height and width throughout the entire stairway, not including landings. II/III

(21) Facilities shall maintain corridors to be free of obstruction**,** *[or]* equipment**,** or supplies not in use. Doors to resident rooms shall not swing into the corridor. II/III

(33) Fire Drills and *[Evacuation Plans.]* **Emergency Preparedness.**

(A) All facilities shall *[develop]* **have** a written plan *[for fire drills and other emergencies and evacuation]* **to meet potential emergencies or disasters** and shall request consultation and assistance annually from a local fire unit **for review of fire and evacuation plans**. If the consultation cannot be obtained, the facility shall inform the state fire marshal *[immediately]* in writing and request assistance in review of the plan. **An up-to-date copy of the facility's entire plan shall be provided to the local jurisdiction's emergency management director.** II/III

(B) The plan shall include, but is not limited to—

1. A phased response ranging from relocation of residents **to an immediate area** within the facility**;** *[to]* relocation to an area of refuge, if applicable*[,]***; or** to total **building** evacuation. This phased response part of the plan shall be consistent with the direction of the local fire unit or state fire marshal and shall be appropriate for the fire or emergency;

2. Written instructions for evacuation of each floor including evacuation to areas of refuge, if applicable, and floor plan showing the location of exits, fire alarm pull stations, fire extinguishers, and any areas of refuge;

3. Evacuating residents, if necessary, from an area of refuge to a point of safety outside the building;

4. The location of any additional water sources on the property such as cisterns, wells, lagoons, ponds, or creeks;

5. Procedures for the safety and comfort of residents evacuated;

6. Staffing assignments;

7. Instructions for staff to call the fire department or other outside emergency services;

8. Instructions for staff to call alternative resource(s) for housing residents, if necessary;

9. Administrative staff responsibilities; and

10. Designation of a staff member to be responsible for accounting for all residents' whereabouts. II/III

(39) All new floor covering installed *[shall be Class I in non-sprinklered buildings and Class II in sprinklered]* **in** buildings **that do not have a sprinkler system shall be Class I** in accordance with NFPA 253, 2000 edition. II/III

(40) Trash and Rubbish Disposal Requirements.

(A) Only metal or UL- or *[Factory Mutual (FM)-]* **FM-**approved wastebaskets shall be used for the collection of trash. II

(41) Minimum *[s]***S**taffing for *[s]***S**afety and *[p]***P**rotective *[o]***O**versight to *[r]***R**esidents *[shall be—]***.**

(A) In a *[fire-resistant or sprinklered]* building*[—]* **that is of fire-resistant construction or a building with a sprinkler system, minimum staffing shall be the following:**

Time	Personnel	Residents
7 a.m. to 3 p.m. (Day)	1	3–10*
3 p.m. to 11 p.m. (Evening)	1	3–15*
11 p.m. to 7 a.m. (Night)	1	3–20*

One (1) additional staff person for every fraction after that[;]***.*** I/II

[or]

(B) In a *[nonfire-resistant, nonsprinklered]* building*[—]* **that is of nonfire-resistant construction or a building that has a sprinkler system exemption, minimum staffing shall be the following:**

Time	Personnel	Residents
7 a.m. to 3 p.m. (Day)	1	3–10*
3 p.m. to 11 p.m. (Evening)	1	3–15*
11 p.m. to 7 a.m. (Night)	1	3–15*

*One (1) additional staff person for every fraction after that. I/II

AUTHORITY: sections 198.074 and 198.079, RSMo Supp. [2008] ***2011****. This rule originally filed as 13 CSR 15-14.022. Original rule filed July 13, 1983, effective Oct. 13, 1983. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed March 15, 2012.*

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions five hundred seventy-seven dollars and eighty cents ($577.80) annually in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities seven thousand nine hundred twenty-eight dollars and seventy cents ($7,928.70) annually in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Teresa Generous, Director of the Division of Regulation and Licensure, PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. **Department Title: Department of Health and Senior Services**
Division Title: Division of Regulation and Licensure
Chapter Title: Chapter 85

Rule Number and Title:	19 CSR 30-85.022 Fire Safety and Emergency Preparedness Standards for New and Existing Intermediate Care and Skilled Nursing Facilities
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Provide the local jurisdiction's emergency management director with an up-to-date copy of the facility's emergency or disaster plan, fire and evacuation plan – 36 Intermediate Care Facilities and Skilled Nursing Facilities	**$577.80**

III. WORKSHEET

Provide an up-to-date copy of the facility's emergency or disaster plan, fire and evacuation plan to the local jurisdiction's emergency management director.

This proposed amendment requires all intermediate care and skilled nursing facilities to have a written plan to meet potential emergencies or disasters and submit an up to date copy of the plans to their local jurisdiction's emergency management director.

IV. ASSUMPTIONS

Provide an up-to-date copy of the facility's emergency or disaster plan, fire and evacuation plan to the local jurisdiction's emergency management director.

This fiscal note is an estimated cost to print and certify mail a copy of the facility's emergency or disaster plan, fire and evacuation plan to the local jurisdiction's emergency management director.

The section utilized the January 18, 2007 version of the Disaster Preparedness Plan *Template for use in* Long Term Care Facilities as a guide for the plans. The template is a 58 page document and the estimate is based on printing one-side of 8 ½ by 11 inch paper.

A. Print and certify mail an emergency or disaster plan, fire and evacuation plan.

1. The cost to print the 58 page template is **$6.00**. Cost to certify mail the 58 page template in a United States Postal Service small flat rate box (up to four (4) lbs)) with a return receipt is **$10.05**.

2. The cost to print **($6.00)** + cost to certify mail **($10.05)** = Total cost for one (1) facility to certify mail an up to date copy of the emergency or disaster plan and fire and evacuation plan **($16.05)**.

3. Total cost to mail an up to date copy of the plans **($16.05)** x total number of facilities **(36)** = Total annual estimated cost in the aggregate for public facilities **($577.80)**.

FISCAL NOTE
PRIVATE COST

I. Department Title: Department of Health and Senior Services
Division Title: Division of Regulation and Licensure
Chapter Title: Chapter 85

Rule Number and Title:	19 CSR 30-85.022 Fire Safety and Emergency Preparedness Standards for New and Existing Intermediate Care and Skilled Nursing Facilities
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
Provide the local jurisdiction's emergency management director with an up-to-date copy of the facility's emergency or disaster plan, fire and evacuation plan – 494 Intermediate Care Facilities and Skilled Nursing Facilities	Intermediate Care Facilities and Skilled Nursing Facilities	**$7,928.70**

III. WORKSHEET

Provide an up-to-date copy of the facility's emergency or disaster plan, fire and evacuation plan to the local jurisdiction's emergency management director.

This proposed amendment requires all intermediate care and skilled nursing facilities to have a written plan to meet potential emergencies or disasters and submit an up to date copy of the plans to their local jurisdiction's emergency management director.

IV. ASSUMPTIONS

Provide an up-to-date copy of the facility's emergency or disaster plan, fire and evacuation plan to the local jurisdiction's emergency management director.

This fiscal note is an estimated cost to print and certify mail a copy of the facility's emergency or disaster plan, fire and evacuation plan to the local jurisdiction's emergency management director.

The section utilized the January 18, 2007 version of the Disaster Preparedness Plan *Template for use in* Long Term Care Facilities as a guide for the plans. The template is a 58 page document and the estimate is based on printing one-side of 8 ½ by 11 inch paper.

A. Print and certify mail an emergency or disaster plan, fire and evacuation plan.

1. The cost to print the 58 page template is **$6.00**. Cost to certify mail the 58 page template in a United States Postal Service small flat rate box (up to four (4) lbs)) with a return receipt is **$10.05**.

2. The cost to print **($6.00)** + cost to certify mail **($10.05)** = Total cost for one (1) facility to certify mail an up to date copy of the emergency or disaster plan and fire and evacuation plan **($16.05)**.

3. Total cost to mail an up to date copy of the plans **($16.05)** x total number of facilities **(494)** = Total annual estimated cost in the aggregate for private facilities **($7,928.70)**.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 86—Residential Care Facilities and Assisted Living Facilities

PROPOSED AMENDMENT

19 CSR 30-86.022 Fire Safety *and Emergency Preparedness* Standards for Residential Care Facilities and Assisted Living Facilities. The department is amending the title of the rule, the purpose statement, editor's note, and sections (1), (5), (7), (9), (10), (11), (12), and (13); deleting section (12); adding section (17); and renumbering sections throughout.

PURPOSE: This amendment adds emergency preparedness requirements, updates and clarifies fire alarm system and sprinkler system requirements, and removes redundancy and archaic language.

*PURPOSE: This rule establishes fire safety **and emergency preparedness** standards for residential care facilities and assisted living facilities.*

*[Editor's Note] **AGENCY NOTE**: All rules relating to long-term care facilities licensed by the [d]**D**epartment **of Health and Senior Services** are followed by a Roman Numeral notation which refers to the class (either class I, II, or III) of standard as designated in section 198.085[.1], RSMo [Supp 1999] **2000**.*

(1) Definitions. For the purpose of this rule, the following definitions shall apply:

(A) Accessible spaces—shall include all rooms, halls, storage areas, basements, attics, lofts, closets, elevator shafts, enclosed stairways, dumbwaiter shafts, and chutes*[.]***;**

(B) Area of refuge—a space located in or immediately adjacent to a path of travel leading to an exit that is protected from the effects of fire, either by means of separation from other spaces in the same building or its location, permitting a delay in evacuation. An area of refuge may be temporarily used as a staging area that provides some relative safety to its occupants while potential emergencies are assessed, decisions are made, and, if applicable, evacuation has begun*[.]***;**

(C) Major renovation—shall include the following:

1. Addition of any room(s), accessible by residents, that either exceeds fifty percent (50%) of the total square footage of the facility or exceeds four thousand five hundred (4,500) square feet; *[or]*

2. Repairs, remodeling, or renovations that involve structural changes to more than fifty percent (50%) of the building; *[or]*

3. Repairs, remodeling, or renovations that involve structural changes to more than four thousand five hundred (4,500) square feet of a smoke section; or

4. If the addition is separated by two- (2-)*[-]* hour fire-resistant construction, only the addition portion shall meet the requirements for NFPA 13, 1999 edition, sprinkler system, unless the facility is otherwise required to meet NFPA 13, 1999 edition*[.]***;**

(D) Fire-resistant construction—type of construction in residential care and assisted living facilities in which bearing walls, columns, and floors are of noncombustible material in accordance with NFPA 101, 2000 edition. All load-bearing walls, floors, and roofs shall have a minimum of a one- (1-)*[-]* hour fire-resistant rating*[.]***; and**

(E) Concealed spaces—shall include areas within the building that cannot be occupied or used for storage.

(5) Fire Drills and *[Evacuation Plans]* **Emergency Preparedness**.

(A) All facilities shall *[develop]* **have** a written plan *[for fire drills and other emergencies and evacuation]* **to meet potential emergencies or disasters** and shall request consultation and assistance annually from a local fire unit **for review of fire and evacuation plans**. If the consultation cannot be obtained, the facility shall inform the state fire marshal in writing and request assistance in review of the plan. **An up-to-date copy of the facility's entire plan shall be provided to the local jurisdiction's emergency management director.** II/III

(B) The plan shall include, but is not limited to, the following:

1. A phased response ranging from relocation of residents **to an immediate area** within the facility**;** *[to]* relocation to an area of refuge, if applicable*[,]***; or** to total **building** evacuation. This phased response part of the plan shall be consistent with the direction of the local fire unit or state fire marshal and appropriate for the fire or emergency;

2. Written instructions for evacuation of each floor including evacuation to areas of refuge, if applicable, and a floor plan showing the location of exits, fire alarm pull stations, fire extinguishers, and any areas of refuge;

3. Evacuating residents, if necessary, from an area of refuge to a point of safety outside the building;

4. The location of any additional water sources on the property such as cisterns, wells, lagoons, ponds, or creeks;

5. Procedures for the safety and comfort of residents evacuated;

6. Staffing assignments;

7. Instructions for staff to call the fire department or other outside emergency services;

8. Instructions for staff to call alternative resource(s) for housing residents, if necessary;

9. Administrative staff responsibilities; and

10. Designation of a staff member to be responsible for accounting for all residents' whereabouts. II/III

(7) Exits, Stairways, and Fire Escapes.

(A) Each floor of a facility shall have at least two (2) unobstructed exits remote from each other. I/II

1. For a facility whose plans were approved on or before December 31, 1987, or a facility licensed for twenty (20) or fewer *[residents]* **beds**, one (1) of the required exits from a multi-story facility shall be an outside stairway or an enclosed stairway that is separated by one- (1-)*[-]* hour rated construction from each floor with an exit leading directly to the outside at grade level. Existing plaster or gypsum board of at least one-half inch (1/2") thickness may be considered equivalent to one- (1-)*[-]* hour rated construction. The other required exit may be an interior stairway leading through corridors or passageways to outside or to a two- (2-)*[-]* hour rated horizontal exit as defined by paragraph 3.3.61 of the 2000 edition NFPA 101. Neither of the required exits shall lead through a furnace or boiler room. Neither of the required exits shall be through a resident's bedroom, unless the bedroom door cannot be locked. I/II

2. For a facility whose plans were approved after December 31, 1987, for more than twenty (20) *[residents]* **beds**, the required exits shall be doors leading directly outside, one- (1-)*[-]* hour enclosed stairs or outside stairs or a two- (2-)*[-]* hour rated horizontal exit as defined by paragraph 3.3.61 of 2000 edition NFPA 101. The one (1)-hour enclosed stairs shall exit directly outside at grade. Access to these shall not be through a resident bedroom or a hazardous area. I/II

3. Only one (1) of the required exits may be a two- (2-)*[-]* hour rated horizontal exit. I/II

(C) In residential care facilities and facilities formerly licensed as residential care facilities II, floors housing residents who require the use of a walker, wheelchair, or other assistive devices or aids, or who are blind, must have two (2) accessible exits to grade or such residents must be housed near accessible exits as specified in 19 CSR 30-86.042(33) for residential care facilities and 19 CSR 30-86.043(31) for facilities formerly licensed as residential care facilities II unless otherwise prohibited by 19 CSR 30-86.045 or 19 CSR 30-86.047, facilities equipped with a complete sprinkler system, in accordance with NFPA 13 or NFPA 13R, 1999 edition, with sprinkler*[ed]* **coverage in** attics, and smoke partitions, as defined by subsection (10)(I) of

this rule, may house such residents on floors that do not have accessible exits to grade if each required exit is equipped with an area of refuge as defined and described in subsections (1)(B) and (7)(D) of this rule. I/II

(D) An "area of refuge" shall have*[:]*—

1. An area separated by one- (1-)*[-]* hour rated smoke walls, from the remainder of the building. This area must have direct access to the exit stairway or access the stair through a section of the corridor that is separated by smoke walls from the remainder of the building. This area may include no more than two (2) resident rooms;

2. A two- (2-)*[-]* way communication or intercom system with both visible and audible signals between the area of refuge and the bottom landing of the exit stairway, attendants' work area, or other primary location as designated in the written plan for fire drills and evacuation;

3. Instructions on the use of the area during emergency conditions that are located in the area of refuge and conspicuously posted adjoining the communication or intercom system;

4. A sign at the entrance to the room that states "AREA OF REFUGE IN CASE OF FIRE" and displays the international symbol of accessibility;

5. An entry or exit door that is at least a one and three-fourths inch (1 3/4") solid core wood door or has a fire protection rating of not less than twenty (20) minutes with smoke seals and positive latching hardware. These doors shall not be lockable;

6. A sign conspicuously posted at the bottom of the exit stairway with a diagram showing each location of the areas of refuge;

7. Emergency lighting for the area of refuge; and

8. The total area of the areas of refuge on a floor shall equal at least twenty (20) square feet for each resident who is blind or requires the use of wheelchair or walker housed on the floor. II

(9) Complete Fire Alarm Systems.

(A) **All** *[F]***f**acilities *[that did not have a complete fire alarm system prior to August 28, 2007,]* shall have a complete fire alarm system installed in accordance with NFPA 101, Section 18.3.4, 2000 edition. The complete fire alarm shall automatically transmit to the fire department, dispatching agency, or central monitoring company. The complete fire alarm system shall include visual signals and audible alarms that can be heard throughout the building and a main panel that interconnects all alarm-activating devices and audible signals. *[At a minimum, the complete fire alarm system shall consist of a m]***M**anual pull station**s shall be installed** at or near each **required** attendant's station and each required exit *[in accordance with NFPA 72, 1999 edition and the following]***.** I/II*[:]*

1. For facilities with a sprinkler system in accordance with NFPA 13, 1999 edition, smoke detectors interconnected to the complete fire alarm system shall be installed in all corridors and spaces open to *[the]* corridor**s**. Smoke detectors shall be no more than thirty feet (30') apart with no point on the ceiling more than twenty-one feet (21') from a smoke detector. I/II

A. In facilities licensed prior to November 13, 1980, smoke detectors located every fifty feet (50') will be acceptable if the distance is within the manufacturer's specifications. I/II

2. For facilities with a sprinkler system in accordance with NFPA 13R, 1999 edition, smoke detectors interconnected to the complete fire alarm system shall be installed in **all** corridors, spaces open to *[the]* corridor**s**, and in accessible spaces **not protected by the sprinkler system**, as required by NFPA 72, 1999 edition*[, not protected by the sprinkler system]*. Smoke detectors shall be no more than thirty feet (30') apart with no point on the ceiling more than twenty-one feet (21') from a smoke detector. Smoke detectors shall not be installed in areas where environmental influences may cause nuisance alarms. Such areas include, but are not limited to**,** kitchens, laundries, bathrooms, mechanical air handling rooms, and attic spaces. In these areas, heat detectors interconnected to the complete fire alarm system shall be installed. Bathrooms not exceeding fifty-five (55) square feet and clothes closets, linen closets, and pantries not exceeding twenty-four (24) square feet are exempt from having any detection device if the walls and ceilings are surfaced with limited-combustible or non-combustible material as defined in NFPA 101, 2000 edition. Concealed spaces of noncombustible or limited combustible construction are not required to have detection devices. These spaces may have limited access but cannot be occupied or used for storage. I/II

A. In facilities licensed prior to November 13, 1980, smoke detectors located every fifty feet (50') will be acceptable if the distance is within the manufacturer's specifications. I/II

3. For facilities *[without an approved sprinkler system]* **that are not required to have a sprinkler system**, smoke detectors interconnected to the complete fire alarm system shall be installed in all accessible spaces, as required by NFPA 72, 1999 edition, within the facility. Smoke detectors shall be no more than thirty feet (30') apart with no point on the ceiling more than twenty-one feet (21') from a smoke detector. Smoke detectors shall not be installed in areas where environmental influences may cause nuisance alarms. Such areas include, but are not limited to**,** kitchens, laundries, bathrooms, mechanical air handling rooms, and attic spaces. In these areas, heat detectors interconnected to the fire alarm system shall be installed. Bathrooms not exceeding fifty-five (55) square feet and clothes closets, linen closets, and pantries not exceeding twenty-four (24) square feet are exempt from having any detection device if the walls and ceilings are surfaced with limited-combustible or noncombustible material as defined in NFPA 101, 2000 edition. Concealed spaces of noncombustible or limited combustible construction are not required to have detection devices. These spaces may have limited access but cannot be occupied or used for storage. I/II

A. In facilities licensed prior to November 13, 1980, smoke detectors located every fifty feet (50') will be acceptable if the distance is within the manufacturer's specifications. I/II

(B) *[Facilities that had a complete fire alarm system prior to August 28, 2007, shall have a complete fire alarm system, in accordance with the applicable edition of NFPA 72, that at a minimum contains the following components: interconnected smoke detectors throughout the facility, automatic transmission to the fire department, dispatching agency, or central monitoring company, manual pull stations at each required exit and attendant's station, heat detectors, and audible and visual alarm indicators. I/II*

1. Smoke detectors interconnected to the complete fire alarm system shall be located no more than thirty feet (30') apart in the corridors or passageways with no point in the corridor or passageway more than fifteen feet (15') from a detector and no point in the building more than thirty feet (30') from a detector. In facilities licensed prior to November 13, 1980, smoke detectors located every fifty feet (50') will be acceptable. I/II

A. Facilities without an approved sprinkler system shall have one (1) or more individual home-type smoke detectors per resident-use room. The individual home-type smoke detectors shall be UL-approved battery-powered detectors which sense smoke and automatically sound an alarm which can be heard throughout the facility. I/II

B. Individual home-type detectors shall be tested monthly and batteries shall be changed as needed. Any fault with any detector shall be corrected immediately upon discovery. A record shall be kept of the dates of testing and the changing of batteries. II/III

2. Heat detectors, interconnected to the fire alarm system, shall be installed in areas where environmental influences may cause nuisance alarms, unless the area is protected by an approved sprinkler system. Such areas include, but are not limited to kitchens, laundries, bathrooms, mechanical air handling rooms, and attic spaces. Bathrooms not exceeding fifty-five (55) square feet are exempt from

having a heat detector if the wall and ceilings are surfaced with limited-combustible or noncombustible material as defined in NFPA 101, 2000 edition. I/II] **Facilities that are required to install a sprinkler system in accordance with section (11) of this rule shall comply with the following requirements:**

1. Until the required sprinkler system is installed, each resident room or any room designated for sleeping shall be equipped with at least one (1) battery-powered smoke alarm installed, tested, and maintained in accordance with manufacturer's specifications. In addition, the facility shall be equipped with interconnected heat detectors installed, tested, and maintained in accordance with NFPA 72, 1999 edition, with detectors in all areas subject to nuisance alarms, including, but not limited to, kitchens, laundries, bathrooms, mechanical air handling rooms, and attic spaces. I/II

A. The facility shall maintain a written record of the monthly testing and battery changes. The written records shall be retained for one (1) year. I/II

B. Upon discovery of a fault with any detector or alarm, the facility shall correct the fault. I/II

(G) Upon discovery of a fault with the complete fire alarm system, the facility shall *[promptly]* correct the fault. I/II

(H) When a complete fire alarm system is to be out-of-service for more than four (4) hours in a twenty-four- (24-)*[-]* hour period, the facility shall immediately notify the department and the local fire authority and implement an approved fire watch in accordance with NFPA 101, 2000 edition, until the complete fire alarm system has returned to full service. I/II

(10) Protection from Hazards.

(A) In assisted living facilities and residential care facilities licensed on or after November 13, 1980, for more than twelve (12) *[residents]* **beds**, hazardous areas shall be separated by construction of at least a one- (1-)*[-]* hour fire-resistant rating. In facilities equipped with a complete fire alarm system, the one- (1-)*[-]* hour fire separation is required only for furnace or boiler rooms. Hazardous areas equipped with a complete sprinkler system are not required to have this one- (1-)*[-]* hour fire separation. Doors to hazardous areas shall be self-closing and shall be kept closed unless an electromagnetic hold-open device is used which is interconnected with the fire alarm system. When the sprinkler option is chosen, the areas shall be separated from other spaces by smoke-resistant partitions and doors. The doors shall be self-closing or automatic-closing. Facilities formerly licensed as residential care facility I or II, and existing prior to November 13, 1980, shall be exempt from this requirement. II

(D) In facilities that are required to comply with the requirements of 19 CSR 30-86.043 and were formerly licensed as residential care facilities II on or after November 13, 1980, each floor shall be separated by construction of at least a one- (1-)*[-]* hour fire-resistant rating. Buildings equipped with a complete sprinkler system may have a nonrated smoke separation barrier between floors. Doors between floors shall be a minimum of one and three-fourths inches (1 3/4") thick and be solid core wood doors or metal doors with an equivalent fire rating. II

(F) Atriums open between floors will be permitted if resident room corridors are separated from the atrium by one- (1-)*[-]* hour rated smoke walls. These corridors must have access to at least one (1) of the required exits without traversing any space opened to the atrium. II

(I) In facilities whose plans were approved or which were initially licensed after December 31, 1987, for more than twenty (20) *[residents]* **beds** and all facilities licensed after August 28, 2007, each smoke section shall be separated by one- (1-)*[-]* hour fire-rated smoke partitions. The smoke partitions shall be continuous from outside wall-to-outside wall and from floor-to-floor or floor-to-roof deck. All doors in this wall shall be at least twenty- (20-)*[-]* minute fire-rated or its equivalent, self-closing, and may be held open only if the door closes automatically upon activation of the complete fire alarm system. II

(J) In all facilities that were initially licensed on or prior to December 31, 1987**,** and all facilities licensed for twenty (20) or fewer beds prior to August 28, 2007, each smoke section shall be separated by a one- (1-)*[-]* hour fire-rated smoke partition that extends from the inside portion of an exterior wall to the inside portion of an exterior wall and from the floor to the underside of the floor or roof deck above, through any concealed spaces, such as those above suspended ceilings, and through interstitial structural and mechanical spaces. Smoke partitions shall be permitted to terminate at the underside of a monolithic or suspending ceiling system where the following conditions are met: The ceiling system forms a continuous membrane, a smoketight joint is provided between the top of the smoke partition and the bottom of the suspended ceiling and the space above the ceiling is not used as a plenum. Smoke partition doors shall be at least twenty- (20-)*[-]* minute fire-rated or its equivalent, self-closing, and may be held open only if the door closes automatically upon activation of the complete fire alarm system. II

(K) Facilities whose plans were approved or which were initially licensed after December 31, 1987, for more than twenty (20) *[residents and]* **beds** which *[are unsprinklered]* **do not have a sprinkler system,** shall have one- (1-)*[-]* hour rated corridor walls with one and three-quarters inch (1 3/4") solid core wood doors or metal doors with an equivalent fire rating. II

(L) If two (2) or more levels of long-term care or two (2) different businesses are located in the same building, the entire building shall meet either the most strict construction and fire safety standards for the combined facility or the facilities shall be separated from the other(s) by two- (2-)*[-]* hour fire-resistant construction. In buildings equipped with a complete sprinkler system in accordance with NFPA 13 or NFPA 13R, 1999 edition, this separation may be rated at one (1) hour. II

(11) Sprinkler Systems.

(A) Facilities licensed on or after August 28, 2007, or any **section of a** facility *[performing]* **in which a** major renovation*[s to the facility]* **has been completed on or after August 28, 2007,** shall *[have]* **install and maintain** a complete sprinkler system *[installed]* in accordance with NFPA 13, 1999 edition. I/II

(B) Facilities that have sprinkler systems installed prior to August 28, 2007, shall *[operate]* **inspect**, maintain, and test these systems in accordance with *[NFPA 13, 1999 edition, or NFPA 13R, 1999 edition, and NFPA 25, 1998 edition]* **the requirements that were in effect for such facilities licensed on August 27, 2007**. I/II

(C) All residential care facilities, and assisted living facilities that do not admit or retain a resident with a physical, cognitive, or other impairment that prevents the individual from safely evacuating the facility with minimal assistance, that were licensed prior to August 28, 2007, with more than twenty (20) residents, and do not have an approved sprinkler system in accordance with NFPA 13, 1999 edition, or NFPA 13R, 1999 edition, shall have until December 31, 2012, to install an approved sprinkler system in accordance with NFPA 13 or 13R, 1999 edition. I/II *[The department shall grant exceptions to this requirement if the facility meets Chapter 33 of NFPA 101, 2000 edition, and the evacuation capability of the facility meets the standards required in NFPA 101A, Guide to Alternative Approaches to Life Safety, 2001 edition. I/II]*

1. The department shall grant exceptions to this requirement if the facility meets Chapter 33 of NFPA 101, 2000 edition, and the evacuation capability of the facility meets the standards required in NFPA 101A, Guide to Alternative Approaches to Life Safety, 2001 edition. I/II

(G) When a sprinkler system is to be out-of-service for more than four (4) hours in a twenty-four- (24-)*[-]* hour period, the facility shall immediately notify the department and implement an approved fire watch in accordance with NFPA 101, 2000 edition, until the sprinkler system has been returned to full service. I/II

[(12) All facilities shall submit, by July 1, 2008, a plan for compliance to the state fire marshal showing how the facility meets the requirements of sections (9) and (11) and subsections (10)(H) and (10)(I) of this rule. If the facility's plan for compliance does not meet the requirements of sections (9) and (11) and subsections (10)(H) and (10)(I) of this rule, the facility shall provide the state fire marshal with a written plan to include at a minimum an explanation of how the requirements of sections (9) and (11) and subsections (10)(H) and (10)(I) will be met, when they will be met, and contact information in the event the plan does not evidence compliance with these requirements. II

(A) To qualify for a sprinkler system exception, the facility shall present evidence to the state fire marshal in writing that the facility meets the safety requirements of Chapter 33 of existing residential board and care occupancies of NFPA 101 Life Safety Code. II]

*[(13)]***(12)** Emergency Lighting.

(A) Emergency lighting of sufficient intensity shall be provided for exits, stairs, resident corridors, and **required** attendants' station. II

(B) The lighting shall be supplied by an emergency service, an automatic emergency generator, or battery-operated lighting system. This emergency lighting system shall be equipped with an automatic transfer switch. II

(C) If battery-powered lights are used, they shall be capable of operating the light for at least one and one-half (1 1/2) hours. II

*[(14)]***(13)** Interior Finish and Furnishings.

(A) In a facility licensed on or after November 13, 1980, for more than twelve (12) *[residents]* **beds**, wall and ceiling surfaces of all occupied rooms and all exitways shall be classified either Class A or B interior finish as defined in NFPA 101, 2000 edition. II

(B) In facilities licensed prior to November 13, 1980, all wall and ceiling surfaces shall be smooth and free of highly combustible materials. II

(C) In *[a]* facilit*[y]***ies** licensed *[on or after November 13, 1980,]* for more than twelve (12) *[residents]* **beds**, the new or replacement floor covering and carpeting *[shall be Class I interior floor finish]* in *[nonsprinklered]* buildings *[and Class II interior floor finish in sprinklered buildings as defined]* **that do not have a sprinkler system shall be Class I** in **accordance with** NFPA *[101]* **253**, 2000 edition. II/III

(D) All *[new or replacement]* curtains and drapes in a licensed facility shall be certified or treated to be flame-resistant as defined in NFPA 101, 2000 edition. II

*[(15)]***(14)** Smoking.

(A) Smoking shall be permitted in designated areas only. Areas where smoking is permitted shall be designated as such and shall be supervised either directly or by a resident informing an employee of the facility that the area is being used for smoking. II/III

(B) Ashtrays shall be made of noncombustible material and safe design and shall be provided in all areas where smoking is permitted. II/III

(C) The contents of ashtrays shall be disposed of properly in receptacles made of noncombustible material. II/III

*[(16)]***(15)** Trash and Rubbish Disposal.

(A) Only metal or UL- or FM-fire-resistant rated wastebaskets shall be used for trash. II

(B) Trash shall be removed from the premises as often as necessary to prevent fire hazards and public health nuisance. II

(C) No trash shall be burned within fifty feet (50') of any facility except in an approved incinerator. I/II

(D) Trash may be burned only in a masonry or metal container. II

(E) The container shall be equipped with a metal cover with openings no larger than one-half inch (1/2") in size. III

*[(17)]***(16)** Standards for Designated Separated Areas.

(A) When a resident resides among the entire general population of the facility, the facility shall take necessary measures to provide such residents with the opportunity to explore the facility and, if appropriate, its grounds. When a resident resides within a designated, separated area that is secured by limited access, the facility shall take necessary measures to provide such residents with the opportunity to explore the separated area and, if appropriate, its grounds. If enclosed or fenced courtyards are provided, residents shall have reasonable access to such courtyards. Enclosed or fenced courtyards that are accessible through a required exit door shall be large enough to provide an area of refuge for fire safety at least thirty feet (30') from the building. Enclosed or fenced courtyards that are accessible through a door other than a required exit shall have no size requirements. II

(B) The facility shall provide freedom of movement for the residents to common areas and to their personal spaces. The facility shall not lock residents out of or inside their rooms. I/II

(C) The facility may allow resident room doors to be locked providing the residents request to lock their doors. Any lock on a resident room door shall not require the use of a key, tool, special knowledge, or effort to lock or unlock the door from inside the resident's room. Only one (1) lock shall be permitted on each door. The facility shall ensure that facility staff has the means or mechanisms necessary to open resident room doors in case of an emergency. I/II

(D) The facility may provide a designated, separated area where residents, who are mentally incapable of negotiating a pathway to safety, reside and receive services and which is secured by limited access if the following conditions are met:

1. Dining rooms, living rooms, activity rooms, and other such common areas shall be provided within the designated, separated area. The total area for common areas within the designated, separated area shall be equal to at least forty (40) square feet per resident; II/III

2. Doors separating the designated, separated area from the remainder of the facility or building shall not be equipped with locks that require a key to open; I/II

3. If locking devices are used on exit doors egressing the facility or on doors accessing the designated, separated area, delayed egress magnetic locks shall be used. These delayed egress devices shall comply with the following:

A. The lock must unlock when the fire alarm is activated;

B. The lock must unlock when the power fails;

C. The lock must unlock within thirty (30) seconds after the release device has been pushed for at least three (3) seconds, and an alarm must sound adjacent to the door;

D. The lock must be manually reset and cannot automatically reset; and

E. A sign shall be posted on the door that reads: PUSH UNTIL ALARM SOUNDS, DOOR CAN BE OPENED IN 30 SECONDS. I/II

4. The delayed egress magnetic locks may also be released by a key pad located adjacent to the door for routine use by staff. I/II

(17) Oxygen usage and storage shall be in accordance with Chapter 8, of NFPA 99, 1999 edition. Oxygen storage rooms exceeding three thousand (3,000) cubic feet shall be separated by one- (1-) hour fire-resistant construction, be equipped with a self-closing door(s), and be mechanically vented to the outside. II/III

*AUTHORITY: sections 198.073, 198.074, and 198.076, RSMo Supp. [2008] **2011**. This rule originally filed as 13 CSR 15-15.022. Original rule filed July 13, 1983, effective Oct. 13, 1983. For intervening history, please consult the **Code of State Regulations**. Amended: Filed March 15, 2012.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500)

in the aggregate. There is a one-time cost to state agencies or political subdivisions of two hundred seventy-two dollars and eighty-five cents ($272.85).

PRIVATE COST: This proposed amendment will cost private entities nine thousand three hundred eighty-nine dollars and twenty-five cents ($9,389.25) in the aggregate, to provide the local jurisdiction's emergency management director with an up-to-date copy of the facility's emergency or disaster plan and fire and evacuation plan and twenty thousand six hundred twenty-two dollars and eighty cents ($20,622.80) in the aggregate to have all curtains and drapes treated to be flame-resistant.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Teresa Generous, Director of the Division of Regulation and Licensure, PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: Department of Health and Senior Services
Division Title: Division of Regulation and Licensure
Chapter Title: Chapter 86

Rule Number and Title:	19 CSR 30-86.022 Fire Safety and Emergency Preparedness Standards for Residential Care Facilities and Assisted Living Facilities
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Provide the local jurisdiction's emergency management director with an up-to-date copy of the facility's emergency or disaster plan, fire and evacuation plan– 17 Residential Care Facilities, Facilities formerly licensed as Residential Care Facility II's and Assisted Living Facilities	**$272.85 This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.**
All curtains and drapes in a licensed facility shall be certified to be flame-resistant as defined in NFPA 101, 2000 Edition – 17 Residential Care Facilities, Facilities formerly licensed as Residential Care Facility II's and Assisted Living Facilities	This proposed amendment does not create a new standard for facilities licensed after July 11, 1980.
All curtains and drapes in a licensed facility shall be treated to be flame-resistant as defined in NFPA 101, 2000 Edition – 17 Residential Care Facilities, Facilities formerly licensed as Residential Care Facility II's and Assisted Living Facilities	This proposed amendment does not create a new standard for facilities licensed after July 11, 1980.

III. WORKSHEET

Provide an up-to-date copy of the facility's emergency or disaster plan, fire and evacuation plan to the local jurisdiction's emergency management director.

This proposed amendment requires all residential care and assisted living facilities to have a written plan to meet potential emergencies or disasters and submit an up to date copy of the plans to their local jurisdiction's emergency management director.

All curtains and drapes shall be certified or treated to be flame-resistant.

A. On July 11, 1980 regulation 13- CSR 15-15.031 subsection (17) (E) became effective. The regulation required newly constructed or facilities licensed after July 11, 1980 to have their curtains or drapes certified as flame-resistant. On June 7, 1982 the same regulation was revised to allow the choice to install certified curtains or drapes or treat these items with a flame-resistant chemical. There are no public facilities that were licensed prior to July 11, 1980. This proposed amendment does not create a new standard for facilities licensed after July 11, 1980.

IV. ASSUMPTIONS

Provide up-to-date copy of the emergency or disaster plan and fire and evacuation plan to the local jurisdiction's emergency management director.

The fiscal note for these facilities is based on the cost to print and certify mail a copy of the facility's emergency or disaster plan and fire and evacuation plan to the local jurisdiction's emergency management director. The section utilized the January 18, 2007 version of the Disaster Preparedness Plan Template (for use in long term care facilities) to estimate facility cost. The template is a 58 page document and the estimate is based on printing one-side of 8 ½ by 11 inch paper.

A. Print and mail emergency or disaster plan and fire and evacuation plan.

1. Cost to print the 58 page template is **$6.00**. Cost to certify mail the 58 page template in a United States Postal Service small flat rate box (up to four (4) lbs)) with a return receipt is **$10.05**.

2. The cost to print **($6.00)** + cost to certify mail **($10.05)** = Total cost for one (1) facility to certify mail an up to date copy of the emergency or disaster plan and fire and evacuation plan **($16.05)**.

3. Total cost to mail an up to date copy of the plans **($16.05)** x total number of facilities **(17)** = Total estimated cost in the aggregate for public facilities **($272.85)**. **This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.**

FISCAL NOTE
PRIVATE COST

I. Department Title: Department of Health and Senior Services
Division Title: Division of Regulation and Licensure
Chapter Title: Chapter 86

Rule Number and Title:	19 CSR 30-86.022 Fire Safety and Emergency Preparedness Standards for Residential Care Facilities and Assisted Living Facilities
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
Provide the local jurisdiction's emergency management director with an up-to-date copy of the facility's emergency or disaster plan, fire and evacuation plan– 585 Residential Care Facilities, Facilities formerly licensed as Residential Care Facility II's and Assisted Living Facilities	Residential Care Facilities, Facilities formerly licensed as Residential Care Facility II's and Assisted Living Facilities	**$9,389.25**
All curtains and drapes in a licensed facility shall be treated to be flame-resistant as defined in NFPA 101, 2000 Edition – 107 Residential Care Facilities, Facilities formerly licensed as Residential Care Facility II's, Assisted Living Facilities	Residential Care Facilities Facilities formerly licensed as Residential Care Facility II's Assisted Living Facilities	**$20,622.80**

III. WORKSHEET

Provide an up-to-date copy of the facility's emergency or disaster plan, fire and evacuation plan to the local jurisdiction's emergency management director.

This proposed amendment requires all residential care and assisted living facilities to have a written plan to meet potential emergencies or disasters and submit an up to date copy of the plans to their local jurisdiction's emergency management director.

All curtains and drapes shall be certified or treated to be flame-resistant.

The proposed amendment requires all residential care and assisted living facilities to have curtains and drapes that are certified as flame-resistant or treated with an approved flame resistant substance.

On July 11, 1980 regulation 13- CSR 15-15.031 subsection (17) (E) became effective. The regulation required newly constructed or facilities licensed after July 11, 1980 to have their curtains or drapes certified as flame-resistant. If new curtains or drapes were installed in a facility that was licensed prior to July 11, 1980 these items would have to be certified as flame-resistant. On June 7, 1982 the same regulation was revised to allow the choice to install certified curtains or drapes or treat these items with a flame-resistant chemical. There are 107 facilities that were licensed prior to July 11, 1980. This fiscal note is based on the assumption that none of these facilities have installed certified or treated their curtains or drapes in 27 - 29 years.

IV. ASSUMPTIONS

Provide up-to-date copy of the facility's emergency or disaster plan, fire and evacuation plan to the local jurisdiction's emergency management director.

The fiscal note for these facilities is based on the cost to print and certify mail a copy of the facility's emergency or disaster plan and fire and evacuation plan to the local jurisdiction's emergency management director. The section utilized the January 18, 2007 version of the Disaster Preparedness Plan Template (for use in long term care facilities) to estimate facility cost. The template is a 58 page document and the estimate is based on printing one-side of 8 ½ by 11 inch paper.

A. Print and mail emergency or disaster plan and fire and evacuation plan.

1. Cost to print the 58 page template is **$6.00**. Cost to certify mail the 58 page template in a United States Postal Service small flat rate box (up to four (4) lbs)) with a return receipt is **$10.05**.

2. The cost to print **($6.00)** + cost to certify mail **($10.05)** = Total cost for one (1) facility to certify mail an up to date copy of the emergency or disaster plan and fire and evacuation plan **($16.05)**.

3. Total cost to mail an up to date copy of the plans **($16.05)** x total number of facilities **(585)** = Total estimated cost in the aggregate for private facilities **($9,389.25)**.

All curtains and drapes shall be certified or treated to be flame-resistant.

The fiscal note for these facilities is based on the cost for treating curtains or drapes. The following formulas have been used to estimate the cost:

A. Treated curtains or drapes

1. The formula for determining the amount of windows is one (1) window per resident. The one (1) window per resident formula has been converted into one (1) resident per one (1) bed. We utilized the number of beds to determine the amount of windows. The total number of beds in private facilities licensed prior to July 11, 1980 is **3,782**.

2. The amount of fabric to cover a 36"x 60" window **(3 yards)** x total number of private facility beds **(3,782)** = Total amount of fabric to cover the windows **(11,346 yards)**.

3. The amount of flame-resistant chemical coverage per gallon is 300 sq ft per gallon **(33 yards)**.

4. The total amount of fabric to cover the windows **(11,346 yards)**/the amount of flame-resistant chemical coverage per gallon **(33 yards)** = Total gallons of flame-resistant chemicals **(344)**.

5. The total gallons of flame-resistant chemicals **(344)** x price per gallon **($59.95)** = Total estimated cost in the aggregate for private facilities **($20,622.80)**.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 88—Resident's Rights and Handling Resident Funds and Property in Long-Term Care Facilities

PROPOSED AMENDMENT

19 CSR 30-88.020 *[Resident's]* ***Residents'*** **Funds and Property**. The department is amending the rule title, the editor's note, purpose statement, and sections (1)–(4), (6)–(14), (16), and (17).

PURPOSE: This amendment updates, clarifies, and adds requirements for handling residents' personal funds and property in long-term care facilities. The amendment also removes redundancy, archaic language, and revises grammar and punctuation throughout.

PURPOSE: This rule establishes standards for protecting [resident's] ***residents'*** *personal funds and property in all types of licensed long-term care facilities.*

[Editor's Note] ***AGENCY NOTE****: All rules relating to long-term care facilities licensed by the [Division of Aging]* ***Department of Health and Senior Services*** *are followed by a Roman Numeral notation which refers to the class (either Class I, II, or III) of standard as designated in section 198.085[.1], RSMo.*

(1) No operator *[shall be]* **is** required **by this rule or by section 198.090, RSMo,** to hold**, manage, safeguard, or account for** any personal funds or money in trust unless some other governmental agency placing residents in the facility makes this a requirement. The record keeping and other requirements of this section apply only to those personal possessions and funds which the facility accepts to hold in trust for the resident as provided in the facility's policy *[and does not apply to other possessions residents have in their rooms or bring into the facility]*.

(2) The *[administrator,]* **operator or** other designated person*[,or both,]* shall use the personal funds of the resident exclusively for the use of the resident and*[,]* only when authorized in writing by the resident, his/her designee *[or legal]***,** guardian **and conservator, or conservator**. A designee shall not be the administrator or an employee of the facility. **With written authorization, the operator may purchase a burial policy for the resident.** II/III

(3) When a resident is admitted, *[s/he and his/her]* **the resident, his/her** designee *[or]***,** guardian **and conservator, or conservator** shall be provided with a statement explaining the facility's policies and resident's rights regarding personal funds. If the facility handles *[resident's]* **residents'** funds, this statement shall include an explanation of the procedure for deposit or withdrawals of funds from any source to the resident or to the resident's account. The facility shall allow the residents access to their personal possessions and funds during regular business hours, Monday through Friday*[.]***, excluding banking holidays.** III

(4) The separate account(s) required to be maintained by section 198.090.1**.**(3), RSMo**,** shall be maintained in a bank or savings and loan association and **if any** interest **is** accrued **it** shall be credited to each resident's account at least *[annually]* **monthly**. *[With written authorization from the resident, the operator may purchase a burial policy for the purpose of burying the resident. III]* **II/III**

(6) A written account for each resident, showing receipts to and disbursements from the personal funds of each resident, shall be maintained. *[These may be kept in one (1) ledger or record or they may be kept individually.]* If the facility policy provides, *[and if appropriate]* or **if** required by another governmental agency, *[two (2)]* **multiple** personal funds accounts may be kept for residents*[—one (1) for clothing allowance and one (1) for spending money]*. III

(7) Receipt of a resident's funds or personal possessions held in trust shall be acknowledged by a written receipt or cancelled check*[s]*. III

(8) Receipts for any purchases made by the operator and paid for from the resident's personal funds shall be kept **pursuant to sections (15) and (16) of this rule** and be available to the resident, his/her designee *[or legal]***,** guardian **and conservator, or conservator**. III

(9) All written accounts of the *[resident's]* **residents'** funds shall be *[brought current]* **reconciled** monthly and a written statement showing the current balance and all transactions shall be given to the resident, his/her designee *[or legal]***,** guardian **and conservator, or conservator** on a quarterly basis. II/III

(10) *[The operator shall have a receipt for the funds and possessions returned to the resident, designee or guardian.]* Within five (5) **calendar** days of the discharge of a resident, the resident *[or]***,** his/her designee *[or]***,** guardian **and conservator, or conservator** shall be given an up-to-date accounting of the resident's personal funds and the balance of the funds and all personal possessions shall be returned to the resident. **This requirement shall not apply for residents discharged due to death, or for residents discharged to hospitals when those residents are expected to return to the facility. The operator shall have a receipt for all funds and possessions returned to the resident, his/her designee, guardian and conservator, or conservator.** II/III

(11) Upon the death of a resident, the operator *[of the facility]* shall *[submit in writing on form MO 886-3103, a complete account of all the resident's remaining personal funds and the name and address of the resident's guardian, conservator, fiduciary of the resident's estate or the individual who was designated to receive the quarterly accounting of all financial transactions made. Personal funds for the purpose of this regulation shall include all the resident's remaining funds with the facility, in any account, with whatever title the account(s) may be known. The complete account of funds shall be submitted within sixty (60) days from the date of the resident's death to the Department of Social Services, Division of Medical Services, TPL Unit, PNA Recovery, P.O. Box 6500, Jefferson City, MO 65102-6500]* **contact the Department of Social Services (DSS), MO HealthNet Division to determine if the deceased resident is a MO HealthNet participant or has been a recipient of aid, assistance, care, services, or if the resident has had moneys expended on his/her behalf by DSS. The facility shall document the contact(s) with and response(s) from DSS**. II/III

(A) If the deceased resident is a MO HealthNet participant or has been a recipient of aid, assistance, care, services, or the resident has had moneys expended on his/her behalf by DSS, the operator shall, in accordance with DSS account balance report requirements, provide DSS with a complete account of all the resident's remaining personal funds and the name and address of the resident's designee, guardian and conservator, or conservator, fiduciary of the resident's estate or the individual who was designated to receive the quarterly accounting of all financial transactions made. Personal funds for the purpose of this regulation shall include all the resident's remaining funds with the facility, in any account, with whatever title the account(s) may be known. II/III

*[(A)]***(B)** None of the resident's personal funds shall be paid to a**n operator**, fiduciary, guardian*[, conservation]* **and conservator, conservator,** or other person until the operator has fully complied with section 198.090.1**.**, RSMo**,** except that funeral expenses may be paid from a resident's personal funds held by a facility if no other

funds are available to cover the cost. If funds are used for this purpose, this fact and the amount used shall be noted on the account report submitted to *[the department]* **DSS** and documentation of payment shall be attached. **II/III**

*[(B)]***(C)** *[Upon receipt of the accounting of the resident's remaining personal funds on form MO 886-3103, the Department of Social Services]* **DSS** will determine the amount of aid, care, assistance**,** or services paid *[by the department. The Department of Social Services]* **and** will notify the operator of the amount determined to have been paid *[by the department]* on behalf of the deceased recipient within sixty (60) days of receipt of the facility operator's accounting**.** *[or within fifteen (15) working days if special request is made by the operator for expediated handling giving the reason(s) for the request, that is, need to comply with contractual or regulatory obligation of another government agency. The amount specified in the notification shall be considered as a claim upon the funds held by the operator. The operator shall pay to the Department of Social Services any remaining personal funds, in the resident's personal fund account, up to the amount determined by the department. Payment shall be made by check payable to the Department of Social Services within sixty (60) working days of the receipt of the demand for payment. Payment shall be made as instructed on the department's claim.]*

(D) The operator may make a special request for expedited response if there is a need to comply with a contractual or regulatory obligation of another governmental agency. The amount specified in the notification shall be considered as a claim upon the funds held by the operator.

(E) The operator shall pay DSS any remaining personal funds in the resident's personal fund account up to the amount determined by DSS. Payment shall be made as instructed by DSS within sixty (60) working days of the receipt of the demand for payment. If additional funds are received by the facility after the initial claim has been filed, the operator shall immediately inform DSS. II/III

*[(C)]***(F)** *[The Department of Social Services]* **DSS** will notify in writing the resident's guardian*[,]* **and** conservator**, conservator**, fiduciary of the resident's estate**,** or the individual who was designated to receive the quarterly accounting of all financial transactions of the amount determined to have been paid by *[the department]* **DSS** on behalf of the deceased resident.

[(D) If there are any remaining personal funds after payment has been issued to the Department of Social Services, then the deceased resident's remaining funds shall be handled in accordance with section 98.090.1(8), RSMo and 13 CSR 15-18.020(12).

(E) Failure of an operator of a facility participating in the Title XIX (Medicaid) program to submit within sixty (60) days of the death of a resident a complete accounting of the remaining personal funds of any resident who has received aid, care, assistance or services from the Department of Social Services shall be a Medicaid program violation under 13 CSR 70-3.030, if the operator had knowledge of such funds, during the sixty (60)-day period. If additional funds are received by the operator after the initial report has been filed, the department shall be immediately informed by the operator.]

(12) *[Upon the death of a resident who, to the operator's knowledge and as confirmed by the department, has not received aid or assistance from the Department of Social Services, if personal funds or possessions are not claimed by a fiduciary within one (1) year of the resident's death, the operator is required to comply, within sixty (60) days of the one (1) year anniversary of the death of the resident, with section 198.090.1(8), RSMo.]* **Upon the death of a resident who has not been a recipient of aid, assistance, care, services, or who has not had moneys expended on the resident's behalf by DSS or DSS has not made claim on the funds, the operator shall provide the fiduciary of resident's estate, at the fiduciary's request, a complete account of all the resident's personal funds and possessions and deliver to the fiduciary all possessions of the resident and the balance of the resident's funds.** II/III

(A) If, after one (1) year from the date of death, no fiduciary makes claim on funds or possessions, the operator shall notify the *[Division of Aging]* **Department of Health and Senior Services (department) in writing**, Attention: *[Institutional Accounting Section,]* **Licensure and Certification Unit, PO Box 570, Jefferson City, MO 65102-0570** that the funds remain unclaimed. This notice shall be sent by the operator within sixty (60) days *[and]***. The notice shall** include the resident's name, Social Security number, date of death**,** and the amount of resident funds or possessions being held belonging to the deceased resident. **II/III**

1. If unclaimed funds in the resident's fund accounts or possessions have a value of *[less than]* one hundred fifty dollars ($150) **or less**, *[and the operator has complied with 42 CFR 483.10(c)(6), if required,]* the funds or proceeds of the sale of the possessions shall be deposited *[after one (1) year]* in a fund for the benefit of all residents of the facility for social and educational activities. **II/III**

2. If unclaimed funds in the resident's fund accounts or possessions have a value of more than one hundred fifty dollars ($150) *[and the operator has complied with 42 CFR 483.10(c)(6), if required, for deceased residents funds, the operator shall hold the unclaimed funds for two (2) years from the date of death. These]* **these** funds **or possessions** shall *[then]* be considered abandoned property under sections 447.500–447.585, RSMo *[and shall be returned to the state of Missouri within sixty (60) days after two (2) years from the date of death. If the operator is a 501(c)(3) corporation, then it shall comply with section 447.540, RSMo]*. The operator shall *[contact the Office of the Treasurer, Unclaimed Property Administrator, P.O. Box 1272, Jefferson City, MO 65102-1272 for instructions and forms to return the unclaimed funds and possessions to the state of Missouri. There shall be an accounting subject to inspection and audit by the Division of Aging or its authorized agents for these unclaimed funds and possessions returned to the state of Missouri]* **report and return the abandoned property to the Missouri State Treasurer in accordance with sections 447.539–447.543, RSMo**. **II/III**

(B) The operator shall keep an accounting of these funds with documentation and receipts and disbursements *[to]* **of** these funds which will be subject to inspection and audit by the *[Division of Aging]* **department**. **II/III**

(13) Any owner, operator, manager, employee**,** or affiliate of an owner or operator receiving personal property or anything with a value of ten dollars ($10) or more from a resident shall make a written statement giving the date of receipt, estimated value**,** and the name of the person making the gift. These statements shall be retained by the operator and made available to the *[Department of Social Services]* **department** or Department of Mental Health as appropriate and to the resident, his/her designee**,** *[or legal]* guardian **and conservator, or conservator**. *[In one (1) calendar year, no]* **No** owner, operator, manager, employee**,** or affiliate of an owner or operator shall **in one (1) calendar year** receive *[from resident's]* **any** personal property or anything of value **from the residents of any facility which have a total value** over one hundred dollars ($100). **These requirements shall not apply to matters deemed exceptions under state law.** II*[/III]*

(14) The bond required by section 198.096, RSMo**,** for operators holding personal funds of residents shall be in a form approved by the *[Division of Aging]* **department** and shall provide that residents who allege that they have been wrongfully deprived of moneys held in trust may bring an action for recovery directly against the surety.

The bond shall be in an amount equal to at least one and one-half (1 1/2) times the average monthly balance of the *[resident's]* **residents'** personal funds, including **residents'** petty cash, or the average total of the monthly balances **for the preceding twelve (12) months**. The average monthly balance(s) **or the average total of the monthly balance(s)** shall be rounded to the nearest one thousand dollars ($1,000). One (1) bond may be used to cover the residents' funds in more than one (1) facility operated by the same operator, if the facility is a multilicensed facility on the same premises. If not on the same premises, then one (1) bond may be used if the bond specifies the amount of coverage provided for each individual facility and the coverage for each facility is a minimum of one thousand dollars ($1,000). II/III *[The director may require an operator to file a bond in an amount greater than one and one-half (1 1/2) times the average total of the balances if the division determines the increase is necessary; the operator is given sixty (60)-days' notice and opportunity for hearing prior to requiring that increase; and the director determines by the evidence presented at any such hearing that the increase is necessary.]*

(16) Records related to resident funds shall be maintained in the facility or shall be available for review and copying, in their entirety, within twenty-four (24) hours of a request for access by the *[Division of Aging]* **department** or its authorized representative. Records kept for the prior seven (7) years, as required in section (15) and under section 198.090, RSMo**,** shall be transferred to a new operator who assumes responsibility for a facility, and if not transferred in **their** entirety, the *[Division of Aging]* **department** shall be notified immediately by the new operator. II/III

(17) If an operator chooses to place a cash deposit in a lending institution in lieu of a bond as referenced in section 198.096.5., RSMo, the amount must be equal to the amount of the bond required and shall be deposited with an insured lending institution pursuant to a noncancellable escrow agreement. The written agreement shall be submitted to the *[division]* **department** and shall be approved prior to license issuance. II

AUTHORITY: sections 198.090 ***and 198.009****, RSMo [Supp. 1993]* ***2000****. This rule originally filed as 13 CSR 15-18.020. Original rule filed July 13, 1983, effective Oct. 13, 1983. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed March 15, 2012.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Teresa Generous, Director of the Division of Regulation and Licensure, PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2110—Missouri Dental Board
Chapter 2—General Rules

PROPOSED AMENDMENT

20 CSR 2110-2.010 Licensure by Examination—Dentists. The board is proposing to amend subsections (1)(E) and (2)(E).

PURPOSE: This amendment outlines the procedure for obtaining a dental license by examination.

(1) To qualify for licensure as set out in sections 332.131 and 332.151, RSMo, each applicant shall—

(E) Hold current certification in *[cardiopulmonary resuscitation (CPR) or basic life support (BLS)]* **the American Heart Association's Basic Life Support for the Healthcare Provider (BLS) or an equivalent certification approved by the Missouri Dental Board. Board-approved courses shall meet the American Heart Association guidelines for cardiopulmonary resuscitation (CPR) and Emergency Cardiovascular Care (ECC) and provide written and manikin testing on the course material by an instructor who is physically present with the students. Online-only courses will not be accepted to satisfy the BLS requirement**.

(2) To apply for a certificate of registration and a license to practice, each applicant shall submit the following:

(E) A copy of his/her current certification in *[cardiopulmonary resuscitation (CPR) or basic life support (BLS)]* **the American Heart Association's Basic Life Support for the Healthcare Provider (BLS) or an equivalent certification approved by the Missouri Dental Board**; and

AUTHORITY: sections 332.031, 332.141, and 332.151, RSMo 2000, ***and*** *section 332.181, RSMo Supp. [2008]* ***2011****. This rule originally filed as 4 CSR 110-2.010. Original rule filed Dec. 12, 1975, effective Jan. 12, 1976. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed March 8, 2012.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Dental Board, PO Box 1367, Jefferson City, MO 65102, by facsimile at 573-751-8216, or via email at dental@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2110—Missouri Dental Board
Chapter 2—General Rules

PROPOSED AMENDMENT

20 CSR 2110-2.030 Licensure by Credentials—Dentists. The board is proposing to amend subsections (1)(F) and (2)(E).

PURPOSE: This amendment outlines the procedure for licensing qualified dentists coming from other states by verification of professional credentials.

(1) To qualify for licensure as set out in section 332.211, RSMo, each applicant shall—

(F) Hold a current certification in *[cardiopulmonary resuscitation (CPR) or basic life support (BLS)]* **the American Heart**

Association's Basic Life Support for the Healthcare Provider (BLS) or an equivalent certification approved by the Missouri Dental Board. Board-approved courses shall meet the American Heart Association guidelines for cardiopulmonary resuscitation (CPR) and Emergency Cardiovascular Care (ECC) and provide written and manikin testing on the course material by an instructor who is physically present with the students. Online-only courses will not be accepted to satisfy the BLS requirement; and

(2) To apply for a certificate of registration and a license to practice, each applicant shall submit the following:

(E) A copy of his/her current certification in *[cardiopulmonary resuscitation (CPR) or basic life support (BLS)]* **the American Heart Association's Basic Life Support for the Healthcare Provider (BLS) or an equivalent certification approved by the Missouri Dental Board**; and

AUTHORITY: sections 332.031 and 332.211, RSMo 2000. This rule originally filed as 4 CSR 110-2.030. Original rule filed Dec. 12, 1975, effective Jan. 12, 1976. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed March 8, 2012.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Dental Board, PO Box 1367, Jefferson City, MO 65102, by facsimile at 573-751-8216, or via email at dental@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2110—Missouri Dental Board
Chapter 2—General Rules

PROPOSED AMENDMENT

20 CSR 2110-2.050 Licensure by Examination—Dental Hygienists. The board is proposing to amend subsections (1)(E) and (2)(E).

PURPOSE: This amendment outlines the procedure for obtaining a dental hygienist license by examination.

(1) To qualify for licensure as set out in sections 332.231 and 332.251, RSMo, each applicant shall—

(E) Hold current certification in *[cardiopulmonary resuscitation (CPR) or basic life support (BLS)]* **the American Heart Association's Basic Life Support for the Healthcare Provider (BLS) or an equivalent certification approved by the Missouri Dental Board. Board-approved courses shall meet the American Heart Association guidelines for cardiopulmonary resuscitation (CPR) and Emergency Cardiovascular Care (ECC) and provide written and manikin testing on the course material by an instructor who is physically present with the students. Online-only courses will not be accepted to satisfy the BLS requirement**.

(2) To apply for a certificate of registration and a license to practice, each applicant shall submit the following:

(E) A copy of his/her current certification in *[cardiopulmonary resuscitation (CPR) or basic life support (BLS)]* **the American Heart Association's Basic Life Support for the Healthcare Provider (BLS) or an equivalent certification approved by the Missouri Dental Board**; and

AUTHORITY: sections 332.031, 332.231, 332.241, and 332.251, RSMo 2000, and section 332.261, RSMo Supp. [2008] 2011. This rule originally filed as 4 CSR 110-2.050. Original rule filed Dec. 12, 1975, effective Jan. 12, 1976. For intervening history, please consult the ***Code of Sate Regulations****. Amended: Filed March 8, 2012.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Dental Board, PO Box 1367, Jefferson City, MO 65102, by facsimile at 573-751-8216, or via email at dental@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2110—Missouri Dental Board
Chapter 2—General Rules

PROPOSED AMENDMENT

20 CSR 2110-2.070 Licensure by Credentials—Dental Hygienists. The board is proposing to amend subsections (1)(F) and (2)(E).

PURPOSE: This amendment outlines the procedure for licensing qualified dental hygienists coming from other states by verification of professional credentials.

(1) To qualify for licensure as set out in section 332.281, RSMo, each applicant shall—

(F) Hold a current certification in *[cardiopulmonary resuscitation (CPR) or basic life support (BLS)]* **the American Heart Association's Basic Life Support for the Healthcare Provider (BLS) or an equivalent certification approved by the Missouri Dental Board. Board-approved courses shall meet the American Heart Association guidelines for cardiopulmonary resuscitation (CPR) and Emergency Cardiovascular Care (ECC) and provide written and manikin testing on the course material by an instructor who is physically present with the students. Online-only courses will not be accepted to satisfy the BLS requirement**; and

(2) To apply for a certificate of registration and a license to practice, each applicant shall submit the following:

(E) A copy of his/her current certification in *[cardiopulmonary resuscitation (CPR) or basic life support (BLS)]* **the American Heart Association's Basic Life Support for the Healthcare Provider (BLS) or an equivalent certification approved by the Missouri Dental Board**; and

AUTHORITY: sections 332.031 and 332.281, RSMo 2000, and section 332.261, RSMo Supp. [2006] 2011. This rule originally filed as 4 CSR 110-2.070. Original rule filed Dec. 12, 1975, effective Jan. 12, 1976. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed March 8, 2012.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Dental Board, PO Box 1367, Jefferson City, MO 65102, by facsimile at 573-751-8216, or via email at dental@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

This section will contain the final text of the rules proposed by agencies. The order of rulemaking is required to contain a citation to the legal authority upon which the order of rulemaking is based; reference to the date and page or pages where the notice of proposed rulemaking was published in the *Missouri Register*; an explanation of any change between the text of the rule as contained in the notice of proposed rulemaking and the text of the rule as finally adopted, together with the reason for any such change; and the full text of any section or subsection of the rule as adopted which has been changed from that contained in the notice of proposed rulemaking. The effective date of the rule shall be not less than thirty (30) days after the date of publication of the revision to the *Code of State Regulations*.

The agency is also required to make a brief summary of the general nature and extent of comments submitted in support of or opposition to the proposed rule and a concise summary of the testimony presented at the hearing, if any, held in connection with the rulemaking, together with a concise summary of the agency's findings with respect to the merits of any such testimony or comments which are opposed in whole or in part to the proposed rule. The ninety (90)-day period during which an agency shall file its order of rulemaking for publication in the *Missouri Register* begins either: 1) after the hearing on the proposed rulemaking is held; or 2) at the end of the time for submission of comments to the agency. During this period, the agency shall file with the secretary of state the order of rulemaking, either putting the proposed rule into effect, with or without further changes, or withdrawing the proposed rule.

Title 9—DEPARTMENT OF MENTAL HEALTH
Division 10—Director, Department of Mental Health
Chapter 5—General Program Procedures

ORDER OF RULEMAKING

By the authority vested in the director of the Department of Mental Health under section 630.050, RSMo Supp. 2011, the department adopts a rule as follows:

9 CSR 10-5.240 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on November 15, 2011 (36 MoReg 2369–2373). Those sections with changes are reprinted here. This proposed rule becomes effective **June 29, 2012**.

SUMMARY OF COMMENTS: The department received comments from (4) individuals on the proposed rule.

COMMENT #1: Teresa Condor and Allyson Ashley of Burrell Behavioral Health commented that in subsection (1)(D) using the words "primary care provider" implies that primary care treatments and management will be conducted at the facility when it will actually be the coordination and management of access to care.

Ms. Condor also commented that in subsection (3)(C), it states "coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines" is unclear. She commented this implies that primary care treatments and management will be conducted at the facility when it will actually be the coordination and management of access to care as noted above. She commented that in subsection (4)(D) the same concern exists.

RESPONSE AND EXPLANATION OF CHANGE: The department agrees with the comment regarding subsection (1)(D) and has revised the rule as requested. The department disagrees that the language in subsection (3)(C) or subsection (4)(D) is unclear. The department notes the previous revision to the rule in subsection (1)(D) should provide clarification.

COMMENT #2: Ms. Condor and Ms. Ashley of Burrell Behavioral Health commented that in paragraph (2)(B)1. three (3) months is an unrealistic expectation to have a contract or Memorandum of Understanding (MOU) developed with regional hospitals.
RESPONSE AND EXPLANATION OF CHANGE: The department agrees with the comment regarding contracts or MOUs recognizing that while a contract or MOU may not be final in three (3) months, it would be under development and revised the rule as requested.

COMMENT #3: Ms. Condor also commented that the phrase in paragraph (2)(B)1. "maintain a mutual awareness and collaboration to identify individuals seeking emergency department services that might benefit from connection with a Home Health site" may pose difficulties because when they reach maximum allocations, they will not be able to enroll more patients. She commented that in subsection (4)(D) the same concern exists.
RESPONSE: The department disagrees that the language would require enrolling more patients than their maximum allocations would allow, and no changes have been made as a result.

COMMENT #4: Ms. Ashley of Burrell Behavioral Health commented that in paragraph (2)(A)2. a requirement to present the approved PowerPoint introduction "Paving the Way for Health Homes" to all staff is not necessary.
RESPONSE: The department recognizes that all staff may be involved with the provision of services to patients, and no changes have been made as a result of the comment.

COMMENT #5: Markus Cicka commented that the use of words such as substantial, routinely, demonstrate, and determined by the Department of Mental Health (DMH), without more specific requirements will make it difficult to conduct an audit, unless those standards are incorporated in their provider manual and incorporated by reference in a rule. Ms. Ashley of Burrell Behavioral Health also commented that in paragraph (2)(A)3. minimum access requirements are not defined.
RESPONSE: The department disagrees that the language is unclear or definitions unavailable and made no changes as a result of the comments.

COMMENT #6: Department staff commented that in section (1) language should be added to define the Missouri Medicaid Audit and Compliance unit (MMAC) and in section (3) language should be added to provide that Community Mental Health Centers (CMHCs) shall work cooperatively with the department to support approved training, technology, and administrative services required for the implementation of the Health Care Home program.
RESPONSE AND EXPLANATION OF CHANGE: The department agrees with these comments and has revised the rule as requested.

9 CSR 10-5.240 Health Home

(1) Definitions.

(D) Health Home (also referred to as Health Care Home)—A site that provides comprehensive behavioral health care coordinated with comprehensive primary physical care to Medicaid patients with behavioral health and/or chronic physical health conditions, using a partnership or team approach between the Health Home practice's/site's health care staff and patients in order to achieve improved primary

care and to avoid hospitalization or emergency room use.

(F) Missouri Medicaid Audit and Compliance Unit (MMAC)—The unit within the Department of Social Services (DSS) which directly manages and administers Medicaid provider review, program integrity, audit and compliance initiatives, and provider contracts of the Medicaid program.

(G) MO HealthNet Division (MHD)—The Missouri Medicaid agency.

(H) Needy individuals—Individuals receiving medical assistance from Medicaid or the Children's Health Insurance Program (CHIP), or are furnished uncompensated care by the provider, or furnished services at either no cost or reduced cost based on a sliding scale.

(2) Health Home Qualifications.

(B) Ongoing Provider Qualifications. Each CMHC must also—

1. Within three (3) months of Health Home service implementation, have a contract or Memorandum of Understanding (MOU) under development with regional hospital(s) or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions of Health Home participants, as well as maintain a mutual awareness and collaboration to identify individuals seeking emergency department (ED) services that might benefit from connection with a Health Home site, and in addition motivate hospital staff to notify the CMHC primary care nurse manager or staff of such opportunities;

2. Develop quality improvement plans to address gaps and opportunities for improvement identified during and after the application process;

3. Demonstrate continuing development of fundamental Health Home functionality at six (6) months and twelve (12) months through an assessment process to be determined by DMH;

4. Demonstrate improvement on clinical indicators specified by and reported to the state; and

5. Meet accreditation standards approved by the state as such standards are developed.

(3) Scope of Services. This section describes the activities CMHCs will be required to engage in and the responsibilities they will fulfill if recognized as a Health Home provider.

(I) CMHCs shall work cooperatively with DMH to support DMH approved training, technology, and administrative services required for implementation of the Health Care Home Program.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 5—Air Quality Standards and Air Pollution Control Rules Specific to the St. Louis Metropolitan Area

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo Supp. 2011, the commission amends a rule as follows:

10 CSR 10-5.040 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2011 (36 MoReg 2232–2233). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received fifteen (15) comments from three (3) sources: U.S. Environmental Protection Agency (EPA) Region 7, Hunt Industrial Service Corporation, and St. Louis County Department of Health.

COMMENT #1: EPA recommended removing the reference to New York style pizza from the exemption for pizza and bakery ovens in subsection (1)(D).
RESPONSE AND EXPLANATION OF CHANGE: Referring to New York style pizza may lead to confusion since there is no consensus on the characteristic that distinguishes New York style pizza from other pizza. Removing the reference to New York style will avoid this confusion without changing the meaning of the exemption. Therefore, the reference to New York style was removed from the exemption for pizza and bakery ovens.

COMMENT #2: EPA commented that record-keeping requirements should be added to section (4) and the records should be retained for at least five (5) years.
RESPONSE AND EXPLANATION OF CHANGE: Suitable record-keeping requirements are a valuable tool for determining compliance. As a result, provisions have been added to section (4) to require sources to keep records to demonstrate compliance, and to maintain the records for at least five (5) years.

COMMENT #3: Hunt Industrial Service Corporation provided a comment letter to support the proposed amendment. They are a small, family-owned business with three (3) hand-fired devices that can be fueled with scrap wood generated by their business activity. Burning this scrap on a limited basis during the cold season would divert solid waste from landfills and utilize low-cost, renewable fuels as an alternative to fossil fuels. The energy harvested from their wood scrap will provide building heat during the winter months.
RESPONSE: The Air Program thanks Hunt Industrial Service Corporation for their support of the proposed amendment. No changes have been made to the rule text as a result of this comment.

COMMENT #4: St. Louis County Health Department does not support the rule amendment as proposed based on several concerns. They do not believe that allowing the burning of biomass or woody waste in places of business for building or process heat is an environmentally sound waste disposal practice or waste disposal option in the St. Louis area. They are concerned that fueling hand-fired equipment with biomass, even if only during the winter months, will result in emissions of particulate matter and black carbon that exacerbate ambient particulate levels and contribute to climate change. Examples were provided of two (2) homemade wood-burning stoves that required enforcement action for stacks emitting black smoke and ash. In both cases, the business claimed to be burning clean wood.
RESPONSE: This project was initiated in late 2009 when a small business in the St. Louis area requested a variance from 10 CSR 10-5.040 to allow them to burn their wood waste for building heat. Their request also asked that the rule be changed to permanently allow this practice. The Missouri Air Conservation Commission approved this request and a rulemaking was started to investigate the use of hand-fired equipment in the St. Louis area. In June 2011, the draft rule text and Regulatory Impact Report were made publicly available for a sixty (60)-day comment period as required by statute. No comments were received during the sixty (60)-day comment period and the proposed amendment was presented for public hearing at the December 8, 2011 meeting of the Missouri Air Conservation Commission. The basic premise of the proposed amendment is to allow the use of suitable fuels in hand-fired equipment at small sources that are below permitting thresholds. Larger sources would still be required to follow the permitting process. The Air Program shares St. Louis County's concerns about particulate matter and all other air emissions in the St. Louis area. To ensure this rulemaking has no impact on St. Louis air quality, the Air Program estimated emissions from small sources using hand-fired equipment fueled with clean, dry wood. These emissions were compared to baseline emissions and the incremental emissions from hand-fired equipment were found to be insignificant. The Air

Program recognizes St. Louis County's concerns regarding climate change impacts from wood burning due to emissions of black carbon. The effect on climate change from combustion of clean wood in the small volumes proposed in the rule amendment would be negligible compared to total emissions in the St. Louis area. At present, Missouri only regulates greenhouse gas emissions as mandated by EPA. The greenhouse gas permitting requirements do not apply to the small sources covered by this rule, nor do they apply to black carbon emissions. In any case, sources affected by this rulemaking must still comply with all applicable state opacity and odor regulations, and any source that becomes a public or private nuisance would be handled on a case-by-case basis. Therefore, no changes have been made to the rule text as a result of this comment.

COMMENT #5: St. Louis County Health Department noted that biomass is not defined in the rule or in 10 CSR 10-6.020 Definitions and Common Reference Tables. They recommended adding a clear definition for biomass or removing it from rule and only allow burning of clean wood.
RESPONSE AND EXPLANATION OF CHANGE: All known sources affected by this rulemaking desire to burn clean wood. Removal of the provision for burning clean biomass would not change the nature of the rulemaking and would minimize confusion regarding allowable fuels. Therefore, all references to clean biomass have been removed from the rule and the list of prohibited fuels has been deleted since it is no longer necessary. The only permissible fuel will be clean, dry wood.

COMMENT #6: St. Louis County Health Department commented that the requirement to follow best combustion practices is too vague and will result in confusion for regulating agencies. Instead, they recommended requiring the units be operated and maintained in accordance with manufacturer's specifications.
RESPONSE AND EXPLANATION OF CHANGE: The requirement to follow best combustion practice is intended to ensure that devices are operated to maximize efficiency and minimize emissions. The terminology of best combustion practice is often associated with Best Available Control Technology (BACT) for larger permitted sources and applying it to small devices regulated in this rule may lead to confusion. Therefore, the requirement has been changed to require hand-fired equipment be operated to minimize emissions at all times, including following all manufacturer's operation and maintenance guidelines. This change makes the requirements for leak-free doors and proper damper operation redundant, and they have been removed. With these deletions, a definition of start-up is no longer required, and it has also been removed from the rule.

COMMENT #7: St. Louis County Health Department recommended that non-manufactured units be prohibited in the rule.
RESPONSE AND EXPLANATION OF CHANGE: The quality of design, testing, and fabrication of homemade equipment would not typically be as high as commercially-manufactured equipment. Homemade equipment also lacks manufacturer's operating and maintenance guidelines. Emissions from homemade equipment would be higher than emissions from commercially-manufactured equipment. Therefore, a provision has been added to the rule that only allows use of hand-fired equipment that is commercially manufactured.

COMMENT #8: St. Louis County Health Department noted that there are no record-keeping requirements for the thirty (30) ton limit on combustion fuel. They recommend that facilities maintain a twelve (12)-month rolling period of type, quantity, and moisture content of materials burned for a sixty (60)-month period.
RESPONSE AND EXPLANATION OF CHANGE: As noted in the response to comment #2, provisions have been added to the rule to require sources to keep records necessary to demonstrate compliance and to maintain the records for at least five (5) years. The per-year limit achieves the same result as the suggested twelve (12)-month rolling period, but requires less burdensome recordkeeping for the small businesses regulated by this rule. To avoid confusion, the thirty (30) ton per year limit has been changed to thirty (30) tons per calendar year.

COMMENT #9: St. Louis County Health Department requested clarification for the basis of the twenty-five percent (25%) moisture content limit for combustion fuel. They asked if the twenty-five percent (25%) is the ideal moisture content for producing minimal emissions.

RESPONSE: The twenty-five percent (25%) maximum moisture content is intended to ensure that only seasoned, dry wood is used as fuel, with the goal of minimizing incomplete combustion and emissions. There is no universally-accepted moisture content that separates dry wood from wet wood, but twenty percent (20%) is the value used in EPA's emission factors documentation. Allowing moisture content up to twenty-five percent (25%) will allow for a reasonable margin of error without significant increases in emissions. Therefore, no changes have been made to the rule text as a result of this comment.

COMMENT #10: St. Louis County Health Department recommended that regulated facilities be required to perform a daily moisture content test on material prior to burning, document the results, and make the records available for review during regulatory inspections.

RESPONSE: Requiring regulated sources, many of which are small businesses, to perform daily moisture content tests is overly burdensome and would not significantly lower emissions from hand-fired devices. Accurately measuring the moisture content of wood in its various forms requires time and equipment that is beyond the capabilities of most sources regulated by this rule. Knowledge of the type and origin of wood waste is sufficient to demonstrate that emissions are being minimized by burning only dry, seasoned fuel. No changes have been made to the rule text as a result of this comment.

COMMENT #11: St. Louis County Health Department noted that some of the language in the proposed amendment appears to be from a model regulation for outdoor hydronic heaters provided by Northeast States for Coordinated Air Use Management (NESCAUM). They request that another part of the same document be added to prohibit any person from operating hand-fired equipment in such a fashion as to create a public or private nuisance.

RESPONSE: The provisions of the proposed amendment for stack height and prohibited fuels are similar to language in the NESCAUM model regulation. As noted in the response to comment #5, the list of prohibited fuels was deleted when biomass fuel was removed from the rule. The proposed requirements, in conjunction with applicable state opacity and odor regulations, are intended to prevent a source from becoming a public or private nuisance. Adding a prohibition on operating hand-fired equipment in such a manner as to create a public or private nuisance is fundamentally redundant. Regulated sources that become a nuisance in spite of compliance with state and local regulations would be handled on a case-by-case basis. No changes have been made to the rule text as a result of this comment.

COMMENT #12: St. Louis County Health Department also noted that the NESCAUM model regulation suggests property line setbacks for outdoor hydronic heaters and requested clarification on whether the rule includes outdoor units and whether the need for property line setbacks had been considered.

RESPONSE: The proposed amendment applies to both indoor and outdoor units and makes no distinction between the two. The property line setbacks suggested by NASCAUM in their model rule range from three hundred (300) feet to five hundred (500) feet and are impractical for sources in urban areas such as St. Louis. As stated in the response to comment #11, regulated sources that become a nuisance would be handled on a case-by-case basis. Therefore, no changes have been made to the rule as a result of this comment.

COMMENT #13: St. Louis County Health Department recommended adding a requirement to post a permanent, conspicuous label summarizing the hand-fired equipment operating procedures, a list of prohibited fuels, a summary of the current visible emission standard, and statements regarding the importance of proper operation and maintenance.
RESPONSE: Labels are not necessary since equipment operation guidelines were added as a result of comment #6. Requiring them would be overly burdensome and impractical for the applicable sources, many of which are small businesses. Therefore, no changes have been made to the rule as a result of this comment.

COMMENT #14: St. Louis County Health Department recommended that hand-fired units only be allowed to operate during non-ozone season, September 16 through April 14, to be consistent with open burning regulations.
RESPONSE: All known sources are small businesses and only plan to operate their hand-fired equipment to provide building heat during the winter months, which is outside any regulatory ozone season. Even if the hand-fired equipment were operated during ozone season, the very small estimated emissions from these devices would have no measureable impact on ground-level ozone levels in the St. Louis area. Therefore, no changes have been made to the rule as a result of this comment.

COMMENT #15: St. Louis County Health Department recommended adding language that only allows burning of clean wood waste generated from a facility's processes. This will prevent a facility from bringing wood from other sources to burn in their device.
RESPONSE AND EXPLANATION OF CHANGE: Adding a restriction that only allows facilities to burn process waste generated onsite is consistent with the intent of the proposed amendment and the appropriate language has been added to the rule.

10 CSR 10-5.040 Control of Emissions From Hand-Fired Equipment

(1) Applicability. This rule shall apply to all hand-fired, fuel-burning equipment at commercial facilities, including, but not limited to furnaces, heating and cooking stoves, and hot water furnaces with the exception of the following:

(D) Ovens that only burn wood, charcoal, or anthracite coal for pizzas or bakery products;

(2) Definitions.

(A) Clean wood—Wood that has not been treated (including, but not limited to, treatment with copper chromium arsenate, creosote, or pentachlorophenol) and has no paint, stain, or any other type of coating.

(B) Definitions of certain terms specified in this rule, other than those defined in this rule section, may be found in 10 CSR 10-6.020.

(3) General Provisions. No owner or operator shall operate applicable hand-fired, fuel-burning equipment unless the following conditions are met:

(A) Hand-fired equipment shall be operated to minimize emissions at all times. This includes, but is not limited to, following all manufacturers' operation and maintenance guidelines;

(B) Hand-fired equipment must be commercially manufactured;

(C) Hand-fired equipment may only burn process waste generated onsite;

(E) Fuel shall be clean wood with a moisture content less than or equal to twenty-five percent (25%); and

(F) Each piece of equipment shall burn no more than thirty (30) tons of fuel per calendar year.

(4) Reporting and Record Keeping.

(A) The owner or operator of hand-fired equipment subject to this rule shall keep records necessary to determine compliance.

(B) Records verifying that only dry wood was used for fuel may be used to demonstrate compliance with the moisture content requirement.

(C) Records required under subsections (4)(A) and (4)(B) of this rule shall be retained by the owner or operator for a minimum of five (5) years. These records shall be made available to the director upon request.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 5—Air Quality Standards and Air Pollution Control Rules Specific to the St. Louis Metropolitan Area

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo Supp. 2011, the commission amends a rule as follows:

10 CSR 10-5.130 Certain Coals to be Washed **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2011 (36 MoReg 2233). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received no comments on the proposed amendment.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 5—Air Quality Standards and Air Pollution Control Rules Specific to the St. Louis Metropolitan Area

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo Supp. 2011, the commission amends a rule as follows:

10 CSR 10-5.455 Control of Emissions From Industrial Solvent Cleaning Operations **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2011 (36 MoReg 2233–2234). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received three (3) comments from three (3) sources: The American Coatings Association, U.S. Paint Corporation, and Lighthouse for the Blind Industries.

Due to similarities in the comments, one (1) response will be provided for all comments.

COMMENT #1: The American Coatings Association supports the

proposed amendment, as it will allow effective process equipment cleaning at coating, ink, and resin manufacturers. They note that similar language is being adopted by many other states.
COMMENT #2: U.S. Paint Corporation supports the proposed amendment. The revised compliance options will allow them to clean their equipment with solvents that are suitable for their specialty coatings without being hazardous to their employees.
COMMENT #3: Lighthouse for the Blind Industries expressed support of the proposed amendment. While they presently are able to comply with the rule, potential changes to their products may make future compliance extremely difficult without the proposed amendment.
RESPONSE: The Air Program thanks the commenters for their support of the proposed amendment. No changes have been made to the rule text as a result of these comments.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 5—Air Quality Standards and Air Pollution Control Rules Specific to the St. Louis Metropolitan Area

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo Supp. 2011, the commission amends a rule as follows:

10 CSR 10-5.490 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2011 (36 MoReg 2234–2246). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received ten (10) comments from three (3) sources on this rule amendment: a representative for the Missouri solid waste industry and the Environmental Industry Association, an attorney representing the IESI Corporation, and the U.S. Environmental Protection Agency (EPA).

Due to the similarity in the following two (2) comments, one (1) response that addresses these comments is at the end of these two (2) comments:

COMMENT #1: The representative for the Missouri solid waste industry and the Environmental Industry Association commented that the industry was not aware of this regulation until it was sent out electronically a few days before the *Missouri Register* came out. In the future it is expected that programs within the department would make each other aware of rulemakings in development so that involved companies can work with staff a little earlier.
COMMENT #2: The attorney representing IESI Corporation commented that he echoed the comments made by the representative for the solid waste industry about involving industry early on in rulemakings before seeing rule actions published in the *Missouri Register*. However, the proposed amendments should be adopted to bring Missouri into compliance with the federal laws. They believe they are already in compliance with these proposed changes because they already meet the federal New Source Performance Standards.
RESPONSE: The Air Program regrets these commenters were not aware of this rulemaking earlier. This rulemaking simply updated state rules for consistency with federal requirements. The Air Program communicated the proposed rulemaking with industry in general and other stakeholders via the Air Forum email listserv and within the department through the rulemaking process prior to filing with the secretary of state on September 26, 2011. The proposed rulemaking was made available for public review and comment by publishing in the *Missouri Register* and posting on the Air Program's Rulemakings on Public Notice webpage on November 1, 2011. However, based on these comments the Air Program is evaluating how to better communicate rulemakings with industry and other programs within the department beyond our current activities. No wording changes have been made to the rule text as a result of these comments.

COMMENT #3: EPA commented that the last sentence in subsection (1)(B) references the Clean Air Act. This reference should be to the *Code of Federal Regulations*.
RESPONSE AND EXPLANATION OF CHANGE: As a result of this comment, the last sentence in subsection (1)(B) has been revised to reference the *Code of Federal Regulations*.

COMMENT #4: EPA commented that subsection (3)(C) was added and discusses incorporation by reference. The EPA does not believe that the reference to 52.21 is relevant to this rule because it relates to the Prevention of Significant Deterioration program and is not relevant for municipal solid waste landfills.
RESPONSE AND EXPLANATION OF CHANGE: As a result of this comment, subsection (3)(C) rule text has been revised to indicate that certain references to the department should be used in place of the federal counterpart for incorporating federal regulations in the state rule.

COMMENT #5: EPA commented for rule 10 CSR 10-6.310 that the rule incorporates by reference the *Code of Federal Regulations* (CFR) as of June 30th. EPA believes the more appropriate date would be July 1st to specifically reference the *Code of Federal Regulations* compilation date.
RESPONSE AND EXPLANATION OF CHANGE: Since rule 10 CSR 10-5.490 also contains a similar incorporation by reference in subsection (3)(C) of the rule and both rule amendments were presented together, EPA's comment on 10 CSR 10-6.310 is also applicable to 10 CSR 10-5.490. Therefore, the first sentence in subsection (3)(C) has been revised to the July 1st date.

COMMENT #6: EPA commented that the citation in subsection (4)(G) is incorrect. There is no paragraph (3)(A)3. and EPA believes the correct citation is paragraph (6)(A)3.
RESPONSE AND EXPLANATION OF CHANGE: As a result of this comment, subsection (4)(G) rule text has been revised with the correct citation to paragraph (6)(A)3.

COMMENT #7: EPA commented that in paragraph (6)(C)1. that words are missing regarding surface monitoring of methane concentrations. The language should include a reference to thirty (30)-meter intervals (or a site-specific established spacing).
RESPONSE AND EXPLANATION OF CHANGE: As a result of this comment, paragraph (6)(C)1. rule text has been revised to include the suggested wording that will match the federal regulation.

COMMENT #8: EPA commented that subparagraph (8)(B)1.B. appears to have a typographical error. The threshold for nonmethane organic compound (NMOC) emissions is set at twenty-five (25) megagrams per year throughout the rule. However, subparagraph (8)(B)1.B. includes the EPA threshold of fifty (50) megagrams and it should be changed to reflect the NMOC emission rate of twenty-five (25) megagrams per year.
RESPONSE AND EXPLANATION OF CHANGE: As a result of this comment, subparagraph (8)(B)1.B. rule text has been changed to the correct value of twenty-five (25).

COMMENT #9: EPA commented that subsection (9)(A) should be

reworded so that the intent related to record-keeping requirements is clear. EPA suggested moving up the third sentence of this paragraph to follow the first sentence of this paragraph in order to identify that the longer period references the on-site requirements rather than the off-site provisions.
RESPONSE AND EXPLANATION OF CHANGE: To make the wording of this subsection clearer, subsection (9)(A) rule text has been revised by moving the proposed third sentence to follow the first sentence.

COMMENT #10: EPA commented that reference is made to subparagraph (9)(B)3.A. in subparagraph (9)(C)1.B. EPA did not find this subparagraph and believes the correct citation may be paragraph (9)(B)3.
RESPONSE AND EXPLANATION OF CHANGE: As a result of this comment, subparagraph (9)(C)1.B. rule text has been revised to the correct citation of paragraph (9)(B)3.

10 CSR 10-5.490 Municipal Solid Waste Landfills

(1) Applicability.

(B) For purposes of obtaining an operating permit under Title V of the Clean Air Act, the owner or operator of an MSW landfill subject to this rule with a design capacity less than two and one-half (2.5) million megagrams or two and one-half (2.5) million cubic meters is not subject to the requirements to obtain an operating permit for the landfill under 40 *Code of Federal Regulations* (CFR) 70 or 71, unless the landfill is otherwise subject to either 40 CFR 70 or 71. For purposes of submitting a timely application for an operating permit under 40 CFR 70 or 71, the owner or operator of an MSW landfill subject to the rule with a design capacity greater than or equal to two and one-half (2.5) million megagrams and two and one-half (2.5) million cubic meters on the effective date of EPA approval of the state's program under section 111(d) of the Clean Air Act (June 23, 1998), and not otherwise subject to either 40 CFR 70 or 71, becomes subject to the requirements of 40 CFR 70.5(a)(1)(i) or 71.5(a)(1)(i) ninety (90) days after the effective date of such 111(d) program approval, even if the design capacity report is submitted earlier.

(3) Standards for Air Emissions from Municipal Solid Waste Landfills. Provisions of 40 CFR 51, 40 CFR 52, 40 CFR 60, and 40 CFR 258 are incorporated by reference in subsection (3)(C) of this rule. Also, the *Compilation of Air Pollutant Emission Factors, Volume I: Stationary Point and Area Sources*, AP-42, Fifth Edition, January 1995 (hereafter AP-42), as published by the Government Printing Office, 732 North Capitol Street NW, Washington, DC, 20401, shall apply and is hereby incorporated by reference, including Supplement E dated November 1998. This rule does not incorporate any subsequent amendments or additions.

(C) The specific citations of 40 CFR 51, 40 CFR 52, 40 CFR 60, and 40 CFR 258 referenced in this rule and published July 1, 2011, shall apply and are hereby incorporated by reference in this rule, as published by the Office of the Federal Register, U.S. National Archives and Records, 700 Pennsylvania Avenue NW, Washington, DC 20408. This rule does not incorporate any subsequent amendments or additions. Certain terms used in 40 CFR refer to federal officers and agencies. The following terms applicable to Missouri shall be substituted where appropriate for the delegable federal counterparts: Director shall be substituted for Administrator and Missouri Department of Natural Resources shall be substituted for EPA, EPA Regional Office, or Environmental Protection Agency.

(4) Operational Standards for Collection and Control Systems. Each owner or operator of an MSW landfill gas collection and control system used to comply with the provisions of subparagraph (3)(B)2.B. of this rule shall—

(G) If monitoring demonstrates that the operational requirements in subsection (4)(B), (C), or (D) of this rule are not met, corrective action shall be taken as specified in paragraphs (6)(A)3. through 5. or subsection (6)(C) of this rule. If corrective actions are taken as specified in section (6) of this rule, the monitored exceedance is not a violation of the operational requirements in this section.

(6) Compliance Provisions.

(C) The following procedures shall be used for compliance with the surface methane operational standard as provided in subsection (4)(D) of this rule:

1. After installation of the collection system, the owner or operator shall monitor surface concentrations of methane along the entire perimeter of the collection area and along a pattern that traverses the landfill at thirty (30)-meter intervals (or a site-specific established spacing) for each collection area on a quarterly basis using an organic vapor analyzer, flame ionization detector, or other portable monitor meeting the specification provided in subsection (6)(D) of this rule.

2. The background concentration shall be determined by moving the probe inlet upwind and downwind outside the boundary of the landfill at a distance of at least thirty (30) meters from the perimeter wells.

3. Surface emission monitoring shall be performed in accordance with section 4.3.1 of Method 21 of 40 CFR 60, Appendix A, except that the probe inlet shall be placed within five to ten centimeters (5–10 cm) of the ground. Monitoring shall be performed during typical meteorological conditions.

4. Any reading of five hundred parts per million (500 ppm) or more above background at any location shall be recorded as an exceedance and the actions specified in subparagraphs (6)(C)4.A. through E. of this rule shall be taken. As long as the specified actions are taken, the exceedance is not a violation of the operational requirements of subsection (4)(D) of this rule.

A. The location of each monitored exceedance shall be marked, and the location recorded.

B. Cover maintenance or adjustments to the vacuum of the adjacent wells to increase the gas collection in the vicinity of each exceedance shall be made, and the location shall be remonitored within ten (10) calendar days of detecting the exceedance.

C. If the remonitoring of the location shows a second exceedance, additional corrective action shall be taken, and the location shall be monitored again within ten (10) days of the second exceedance. If the remonitoring shows a third exceedance for the same location, the action specified in subparagraph (6)(C)4.E. of this rule shall be taken, and no further monitoring of that location is required until the action specified in subparagraph (6)(C)4.E. of this rule has been taken.

D. Any location that initially showed an exceedance but has a methane concentration less than five hundred parts per million (500 ppm) methane above background at the ten (10)-day remonitoring specified in subparagraph (6)(C)4.B. or C. of this rule shall be remonitored one (1) month from the initial exceedance. If the one (1)-month remonitoring shows a concentration less than five hundred parts per million (500 ppm) above background, no further monitoring of that location is required until the next quarterly monitoring period. If the one (1)-month remonitoring shows an exceedance, the actions specified in subparagraph (6)(C)4.C. or E. of this rule shall be taken.

E. When any location equals or exceeds five hundred parts per million (500 ppm) methane above background three (3) times within a quarterly period, a new well or other collection device shall be installed within one hundred twenty (120) calendar days of the initial exceedance. An alternative remedy to the exceedance, such as upgrading the blower, header pipes, or control device, and a corresponding time line for installation may be submitted to the director for written approval.

5. The owner or operator shall implement a program to monitor for cover integrity and implement cover repairs as necessary on a monthly basis.

(8) Reporting Requirements. Except as provided in part (3)(B)2.A.(II) of this rule—

(B) Each owner or operator subject to the requirements of this rule shall submit an NMOC emission rate report to the director initially and annually thereafter, except as provided for in subparagraph (8)(B)1.B. or paragraph (8)(B)3. of this rule. The director may request such additional information as may be necessary to verify the reported NMOC emission rate.

1. The NMOC emission rate report shall contain an annual or five (5)-year estimate of the NMOC emission rate calculated using the formula and procedures provided in subsection (5)(A) or (B) of this rule, as applicable.

A. The initial NMOC emission rate report shall be submitted within ninety (90) days of the rule effective date and may be combined with the initial design capacity report required in subsection (8)(A) of this rule. Subsequent NMOC emission rate reports shall be submitted annually thereafter, except as provided for in subparagraph (8)(B)1.B. and paragraph (8)(B)3. of this rule.

B. If the estimated NMOC emission rate as reported in the annual report to the director is less than twenty-five (25) megagrams per year in each of the next five (5) consecutive years, the owner or operator may elect to submit an estimate of the NMOC emission rate for the next five (5)-year period in lieu of the annual report. This estimate shall include the current amount of solid waste-in-place and the estimated waste acceptance rate for each year of the five (5) years for which an NMOC emission rate is estimated. All data and calculations upon which this estimate is based shall be provided to the director. This estimate shall be revised at least once every five (5) years. If the actual waste acceptance rate exceeds the estimated waste acceptance rate in any year reported in the five (5)-year estimate, a revised five (5)-year estimate shall be submitted to the director. The revised estimate shall cover the five (5)-year period beginning with the year in which the actual waste acceptance rate exceeded the estimated waste acceptance rate.

2. The NMOC emission rate report shall include all the data, calculations, sample reports, and measurements used to estimate the annual or five (5)-year emissions.

3. Each owner or operator subject to the requirements of this rule is exempted from the requirements of paragraphs (8)(B)1. and 2. of this rule after the installation of a collection and control system in compliance with paragraph (3)(B)2. of this rule, during such time as the collection and control system is in operation and in compliance with sections (4) and (6) of this rule.

(9) Record-Keeping Requirements. Except as provided in part (3)(B)2.A.(II) of this rule—

(A) Each owner or operator of an MSW landfill subject to the provisions of subsection (3)(B) of this rule shall keep for at least five (5) years up-to-date, readily accessible, on-site records of the design capacity report which triggered subsection (3)(B) of this rule, the current amount of solid waste-in-place, and the year-by-year waste acceptance rate. A longer period is acceptable if records are needed for an unresolved enforcement action. Records may be maintained off-site if they are retrievable within four (4) hours. Either paper copy or electronic formats are acceptable;

(C) Each owner or operator of a controlled landfill subject to the provisions of this rule shall keep for five (5) years up-to-date, readily accessible continuous records of the equipment operating parameters specified to be monitored in section (7) of this rule as well as up-to-date, readily accessible records for periods of operation during which the parameter boundaries established during the most recent performance test are exceeded.

1. The following constitute exceedances that shall be recorded and reported under subsection (8)(F) of this rule:

A. For enclosed combustors except for boilers and process heaters with design heat input capacity of forty-four (44) megawatts (150 million British thermal units per hour) or greater, all three (3)-hour periods of operation during which the average combustion temperature was more than twenty-eight degrees Celsius (28 °C) below the average combustion temperature during the most recent performance test at which compliance with subparagraph (3)(B)2.C. of this rule was determined; and

B. For boilers or process heaters, whenever there is a change in the location at which the vent stream is introduced into the flame zone as required under paragraph (9)(B)3. of this rule.

2. Each owner or operator subject to the provisions of this rule shall keep up-to-date, readily accessible continuous records of the indication of flow to the control device or the indication of bypass flow or records of monthly inspections of car-seals or lock-and-key configurations used to seal bypass lines, specified under section (7) of this rule.

3. Each owner or operator subject to the provisions of this rule who uses a boiler or process heater with a design heat input capacity of forty-four (44) megawatts or greater to comply with subparagraph (3)(B)2.C. of this rule shall keep an up-to-date, readily accessible record of all periods of operation of the boiler or process heater. (Examples of such records could include records of steam use, fuel use, or monitoring data collected pursuant to other state or local regulatory requirements.)

4. Each owner or operator seeking to comply with the provisions of this rule by use of an open flare shall keep up-to-date, readily accessible continuous records of the flame or flare pilot flame monitoring specified under subsection (7)(C) of this rule and up-to-date, readily accessible records of all periods of operation in which the flame or flare pilot flame is absent;

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 6—Air Quality Standards, Definitions, Sampling and Reference Methods and Air Pollution Control Regulations for the Entire State of Missouri

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo Supp. 2011, the commission amends a rule as follows:

10 CSR 10-6.020 Definitions and Common Reference Tables **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2011 (36 MoReg 2246–2260). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received no comments on the proposed amendment.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 6—Air Quality Standards, Definitions, Sampling and Reference Methods and Air Pollution Control Regulations for the Entire State of Missouri

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo Supp. 2011, the commission amends a rule as follows:

10 CSR 10-6.310 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2011 (36 MoReg 2260–2269). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received five (5) comments from three (3) sources on this rule amendment: a representative for the Missouri solid waste industry and the Environmental Industry Association, an attorney representing the IESI Corporation, and the U.S. Environmental Protection Agency (EPA).

Due to the similarity in the following two (2) comments, one (1) response that addresses these comments is at the end of these two (2) comments:

COMMENT #1: The representative for the Missouri solid waste industry and the Environmental Industry Association commented that the industry was not aware of this regulation until it was sent out electronically a few days before the *Missouri Register* came out. In the future it is expected that programs within the department would make each other aware of rulemakings in development so that involved companies can work with staff a little earlier.

COMMENT #2: The attorney representing IESI Corporation commented that he echoed the comments made by the representative for the solid waste industry about involving industry early on in rulemakings before seeing rule actions published in the *Missouri Register*. However, the proposed amendments should be adopted to bring Missouri into compliance with the federal laws. They believe they are already in compliance with these proposed changes because they already meet the federal New Source Performance Standards.

RESPONSE: The Air Program regrets these commenters were not aware of this rulemaking earlier. This rulemaking simply updated state rules for consistency with federal requirements. The Air Program communicated the proposed rulemaking with industry in general and other stakeholders via the Air Forum email listserv and within the department through the rulemaking process prior to filing with the secretary of state on September 26, 2011. The proposed rulemaking was made available for public review and comment by publishing in the *Missouri Register* and posting on the Air Program's Rulemakings on Public Notice webpage on November 1, 2011. However, based on these comments the Air Program is evaluating how to better communicate rulemakings with industry and other programs within the department beyond our current activities. No wording changes have been made to the rule text as a result of this comment.

COMMENT #3: EPA commented for rule 10 CSR 10-5.490 that a reference to the Clean Air Act found in section (1) should be corrected to the *Code of Federal Regulations*.

RESPONSE AND EXPLANATION OF CHANGE: Since rule 10 CSR 10-6.310 also contains a similar reference to the Clean Air Act in section (1) of the rule and both rule amendments were presented together, EPA's comment on 10 CSR 10-5.490 is also applicable to 10 CSR 10-6.310. Therefore, the last sentence in subsection (1)(D) has been revised to reference the *Code of Federal Regulations*.

COMMENT #4: EPA commented that section (3) incorporates by reference the *Code of Federal Regulations* (CFR) as of June 30th. EPA believes the more appropriate date would be July 1st to specifically reference the *Code of Federal Regulations* compilation date.

RESPONSE AND EXPLANATION OF CHANGE: As a result of this comment, subsection (3)(C) rule text has been revised to change the June 30th date to July 1st.

COMMENT #5: EPA commented that subsection (3)(C) was added and discusses incorporation by reference. The EPA does not believe that the reference to 40 CFR 52.21, is relevant to this rule because it relates to the Prevention of Significant Deterioration program and is not relevant for municipal solid waste landfills.

RESPONSE AND EXPLANATION OF CHANGE: As a result of this comment, subsection (3)(C) rule text has been revised to indicate that certain references to the department should be used in place of the federal counterpart for incorporating federal regulations in the state rule.

10 CSR 10-6.310 Restriction of Emissions From Municipal Solid Waste Landfills

(1) Applicability.

(D) For purposes of obtaining an operating permit under Title V of the Clean Air Act, the owner or operator of an MSW landfill subject to this rule with a design capacity less than two and one-half (2.5) million megagrams or two and one-half (2.5) million cubic meters is not subject to the requirements to obtain an operating permit for the landfill under 40 *Code of Federal Regulations* (CFR) 70 or 71, unless the landfill is otherwise subject to either 40 CFR 70 or 71. For purposes of submitting a timely application for an operating permit under 40 CFR 70 or 71, the owner or operator of an MSW landfill subject to the rule with a design capacity greater than or equal to two and one-half (2.5) million megagrams and two and one-half (2.5) million cubic meters on the effective date of EPA approval of the state's program under section 111(d) of the Clean Air Act (June 23, 1998), and not otherwise subject to either 40 CFR 70 or 71, becomes subject to the requirements of 40 CFR 70.5(a)(1)(i) or 71.5(a)(1)(i) ninety (90) days after the effective date of such 111(d) program approval, even if the design capacity report is submitted earlier.

(3) Standards for Air Emissions from Municipal Solid Waste Landfills. Provisions of 40 CFR 51, 40 CFR 52, 40 CFR 60, and 40 CFR 258 are incorporated by reference in subsection (3)(C) of this rule. Also, the *Compilation of Air Pollutant Emission Factors, Volume I: Stationary Point and Area Sources*, AP-42, Fifth Edition, January 1995 (hereafter AP-42), as published by the Government Printing Office, 732 North Capitol Street NW, Washington, DC 20401, shall apply and is hereby incorporated by reference, including Supplement E dated November 1998. This rule does not incorporate any subsequent amendments or additions.

(C) The specific citations of 40 CFR 51, 40 CFR 52, 40 CFR 60, and 40 CFR 258 referenced in this rule and published July 1, 2011, shall apply and are hereby incorporated by reference in this rule, as published by the Office of the Federal Register, U.S. National Archives and Records, 700 Pennsylvania Avenue NW, Washington, DC 20408. This rule does not incorporate any subsequent amendments or additions. Certain terms used in 40 CFR refer to federal officers and agencies. The following terms applicable to Missouri shall be substituted where appropriate for the delegable federal counterparts: Director shall be substituted for Administrator, and Missouri Department of Natural Resources shall be substituted for EPA, EPA Regional Office, or Environmental Protection Agency:

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 6—Air Quality Standards, Definitions, Sampling and Reference Methods and Air Pollution Control Regulations for the Entire State of Missouri

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo Supp. 2011, the commission amends a rule as follows:

10 CSR 10-6.400 Restriction of Emission of Particulate Matter From Industrial Processes **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2011 (36 MoReg 2269–2270). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received no comments on the proposed amendment.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2030—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects
Chapter 2—Code of Professional Conduct

ORDER OF RULEMAKING

By the authority vested in the Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects under section 327.041, RSMo Supp. 2011, the board amends a rule as follows:

20 CSR 2030-2.040 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2701). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received one (1) comment on the proposed amendment.

COMMENT #1: A comment was submitted by Chris Davis on behalf of AIA Missouri. The comment was in support of the change; however, it was suggested that the amendment be further clarified to reflect the 2012 International Building Code, Section 107 so that there would be a reference to the latest code version.
RESPONSE AND EXPLANATION OF CHANGE: The board reviewed the comment and agreed that the proposed amendment should be revised to make reference to the 2012 International Building Code instead of the 2009 version.

20 CSR 2030-2.040 Standard of Care

PURPOSE: This rule provides the recipient and producer of professional architectural, engineering, and/or landscape architectural services assurances that all services are evaluated in accordance with the 2012 edition of the International Building Code, Section 107.

(1) The board shall use, in the absence of any local building code, Section 107 only of the 2012 edition of the *International Building Code*, not including or applying any other sections referenced within Section 107, as the standard of care in determining the appropriate conduct for any professional licensed or regulated by this chapter and being evaluated under section 327.441.2.(5), RSMo. The *International Code Council*, 2012 Edition is incorporated herein by reference and may be obtained by contacting 500 New Jersey Ave NW, 6th Floor, Washington, DC 20001, by phone at (888) ICC-SAFE (422-7233), by fax at (202) 783-2348, or by their direct website at http://www.iccsafe.org. This rule does not incorporate any subsequent amendments or additions to the manual.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2030—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects
Chapter 2—Code of Professional Conduct

ORDER OF RULEMAKING

By the authority vested in the Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects under sections 327.041 and 327.411, RSMo Supp. 2011, the board amends a rule as follows:

20 CSR 2030-2.050 Title Block **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2701). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2030—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects
Chapter 11—Renewals

ORDER OF RULEMAKING

By the authority vested in the Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects under section 327.041, RSMo Supp. 2011, and section 327.261, RSMo 2000, the board amends a rule as follows:

20 CSR 2030-11.015 Continuing Professional Competency for Professional Engineers **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2701–2702). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2030—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects
Chapter 11—Renewals

ORDER OF RULEMAKING

By the authority vested in the Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects under sections 327.041 and 327.621, RSMo Supp. 2011, and sections 41.946 and 327.171, RSMo 2000, the board amends a rule as follows:

20 CSR 2030-11.035 Continuing Education for Landscape Architects **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2702). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations.*

SUMMARY OF COMMENTS: No comments were received.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2030—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects
Chapter 14—Definitions

ORDER OF RULEMAKING

By the authority vested in the Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects under section 327.041, RSMo Supp. 2011, the board rescinds a rule as follows:

20 CSR 2030-14.050 Definition of Degree in Science as Used in Section 327.391, RSMo **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2702–2703). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations.*

SUMMARY OF COMMENTS: No comments were received.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2145—Missouri Board of Geologist Registration
Chapter 1—General Rules

ORDER OF RULEMAKING

By the authority vested in the Missouri Board of Geologist Registration under section 256.465.2., RSMo Supp. 2011, the board amends a rule as follows:

20 CSR 2145-1.040 Fees **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 3, 2012 (37 MoReg 45–47). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations.*

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 1—General Organization

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-1.010 General Organization **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2711–2712). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 1—General Organization

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-1.020 Public Records **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2712). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.010 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2712–2719). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received two (2) comments on the proposed amendment.

COMMENT #1: MCHCP staff commented that definitions for "active employee" and "long-term disability" should be added to the rule and definitions for survivor, terminated vested subscriber, and vested subscriber need clarification without referencing another rule.
RESPONSE AND EXPLANATION OF CHANGE: Based on this comment, definitions for "active employee" and "long-term disability subscriber" were added, the definitions for survivor, terminated vested subscriber, and vested subscriber have been clarified, and definitions and citations have been renumbered as needed.

COMMENT #2: The Missouri State Medical Association (MSMA), commented that, under the definition of "doctor/physician," psychiatrists do not need to be listed separately, as a psychiatrist is a doctor of medicine or doctor of osteopathy. MSMA also commented that the definition of "provider" includes "therapist with a PhD or Master's Degree in Psychiatry," when there are no PhD or masters degree in psychiatry.
RESPONSE AND EXPLANATION OF CHANGE: Based on this comment, psychiatrist is removed from the definition of "doctor/physician," as a psychiatrist is already included in doctor of medicine or doctor of osteopathy, and the definition of provider is amended to include a "therapist with a PhD or Master's Degree in Psychology or Counseling."

22 CSR 10-2.010 Definitions

(2) Active employee. A benefit-eligible person employed by the state or agency of the state who meets the plan eligibility requirements.

(3) Activities of daily living. Bathing, dressing, toileting, and associated personal hygiene; transferring (being moved in and out of a bed, chair, wheelchair, tub, or shower); mobility, eating (getting nourishment into the body by any means other than intravenous), and continence (voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene).

(4) Administrative appeal. A written request submitted by or on behalf of a member involving plan-related administrative issues such as eligibility, effective dates of coverage, and plan changes.

(5) Adverse benefit determination. An adverse benefit determination means any of the following:
(A) A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit based on a determination of an individual's eligibility to participate in the plan;
(B) A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, or a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental, investigational, or not medically necessary or appropriate; or
(C) Rescission of coverage after an individual has been covered under the plan.

(6) Allowable amount. Maximum amount on which payment is based for covered health care services. This may be called eligible expense, payment allowance, or negotiated rate. If the provider charges more than the allowed amount, the member may be balance-billed (see balance billing, section (8)).

(7) Applied behavior analysis. The design, implementation, and evaluation of environmental modifications, using behavior stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of observation, measurement, and functional analysis of the relationship between environment and behavior.

(8) Balance billing. When a provider bills for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is one hundred dollars ($100) and the allowed amount is seventy dollars ($70), the provider may bill the member for the remaining thirty dollars ($30). A network provider may not balance bill.

(9) Benefits. Health care services covered by the plan.

(10) Board. The board of trustees of the Missouri Consolidated Health Care Plan (MCHCP).

(11) Cancellation of coverage. The ending of medical, dental, or vision coverage per a subscriber's voluntary request.

(12) Case management. A coordinated set of activities conducted for individual patient management of serious or complicated health conditions.

(13) Claims administrator. An organization or group responsible for the processing of claims and associated services for a health plan.

(14) Coinsurance. The member's share of the costs of a covered health care service, calculated as a percent (for example, twenty percent (20%)) of the allowed amount for the service. The member pays coinsurance plus any deductibles owed. For example, if the health insurance or plan's allowed amount for an office visit is one hundred dollars ($100) and the member has met his/her deductible, the member's coinsurance payment of twenty percent (20%) would be twenty dollars ($20). The health insurance or plan pays the rest of the allowed amount.

(15) Congenital defect. Existing or dating from birth. Acquired through development while in the uterus.

(16) Copayment. A fixed amount, for example, fifteen dollars ($15), the member pays for a covered health care service, usually when the member receives the service. The amount can vary by the type of covered health care service.

(17) Date of service. Date medical services are received.

(18) Deductible. The amount the member owes for health care services that the health plan covers before the member's health plan begins to pay. For example, if the deductible is one thousand dollars ($1,000), the member's plan will not pay anything until s/he meets his/her one thousand dollars ($1,000) deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

(19) Disease management. A program offered to members, who do not have primary Medicare coverage, to help manage certain chronic diseases.

(20) Doctor/physician. A licensed practitioner of the healing arts, as approved by the plan administrator, including:
(A) Doctor of medicine;
(B) Doctor of osteopathy;
(C) Podiatrist;
(D) Optometrist;
(E) Chiropractor;
(F) Psychologist;
(G) Doctor of dental medicine, including dental surgery;
(H) Doctor of dentistry; or
(I) Qualified practitioner of spiritual healing whose organization is

generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.

(21) Effective date. The date on which coverage takes effect as described in 22 CSR 10-2.020(4).

(22) Eligibility date. The first day a member is qualified to enroll for coverage as described in 22 CSR 10-2.020(2).

(23) Eligibility period. The time allowed to enroll in accordance with the rules in this chapter.

(24) Emergency medical condition. The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

(A) Placing a person's health in significant jeopardy;

(B) Serious impairment to a bodily function;

(C) Serious dysfunction of any bodily organ or part;

(D) Inadequately controlled pain; or

(E) With respect to a pregnant woman who is having contractions—

1. That there is inadequate time to effect a safe transfer to another hospital before delivery; or

2. That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

(25) Emergency services. With respect to an emergency medical condition—

(A) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department to evaluate such emergency medical condition; and

(B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required to stabilize the patient. The term "to stabilize" means to provide such medical treatment of the condition as may be necessary to ensure, within reasonable medical probability that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility.

(26) Employee. A benefit-eligible person employed by the state and present and future retirees from state employment who meet the plan-eligibility requirements.

(27) Employer. The state department or agency that employs the eligible employee.

(28) Essential benefits. The plan covers essential benefits as required by the Patient Protection and Affordable Care Act. Essential benefits include:

(A) Ambulatory patient services—office visits, urgent care, outpatient diagnostic procedures, outpatient surgery, and outpatient hospice;

(B) Emergency services—ambulance services and emergency room services;

(C) Hospitalization—inpatient hospital benefits, inpatient surgery, transplants, and inpatient hospice;

(D) Maternity and newborn care—maternity coverage and newborn screenings;

(E) Mental health and substance abuse disorder services, including behavioral health treatment—inpatient and outpatient and mental health/chemical dependency office visits;

(F) Prescription drugs;

(G) Rehabilitative and habilitative services and devices—durable medical equipment; cardiac and pulmonary rehabilitation; outpatient physical, speech, and occupational therapy; and home health care;

(H) Laboratory services—lab and X-ray;

(I) Preventive and wellness services and chronic disease management; and

(J) Pediatric services, including oral and vision care—routine vision exam, dental care/accidental injury, immunizations, preventive services, and newborn screenings.

(29) Excluded services. Health care services that the member's health plan does not pay for or cover.

(30) Executive director. The chief executive officer of the Missouri Consolidated Health Care Plan (MCHCP), who shall have charge of the offices, records, and employees of the plan, subject to the direction of the board of trustees.

(31) Experimental/investigational/unproven. A treatment, procedure, device, or drug that meets any of the criteria listed below and that the plan administrator determines, in the exercise of its discretion, is considered experimental/investigational/unproven and is not eligible for coverage under the plan—

(A) Has not received the approval of the U.S. Food and Drug Administration for marketing the drug or device at the time it is furnished, if such approval is required by law;

(B) Is shown by reliable evidence to be the subject of ongoing Phase I clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficiency, or its efficacy as compared with the standard means of treatment or diagnosis; or

(C) Is shown by reliable evidence that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficiency as compared with the standard means of treatment or diagnosis.

(D) Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community.

(32) Formulary. A list of U.S. Food and Drug Administration approved drugs and supplies developed by the pharmacy benefit manager and covered by the plan administrator.

(33) Generic drug. The chemical equivalent of a brand-name drug with an expired patent. The color or shape may be different, but the active ingredients must be the same for both.

(34) Health assessment (HA). A questionnaire about a member's health and lifestyle habits required for participation in the Lifestyle Ladder program.

(35) Health savings account (HSA). A tax-advantaged savings account that may be used to pay for current or future qualified medical expenses. Enrollment in the plan's qualified High Deductible Health Plan is required for participation in an HSA.

(36) High Deductible Health Plan (HDHP). A health plan with a higher deductible than a traditional health plan that, when combined with an HSA, provides a tax-advantaged way to help save for future medical expenses.

(37) Illness. Any bodily sickness, disease, or mental/nervous disorder. For purposes of this plan, pregnancy is considered an illness.

(38) Incident. A definite and separate occurrence of a condition.

(39) Injury. A condition that results independently of an illness and all other causes and is a result of an external force or accident.

(40) Lifetime maximum. The amount payable by a medical plan during a covered member's life for specific non-essential benefits.

(41) Long-term disability subscriber. A subscriber eligible for long-term disability coverage from Missouri State Employees' Retirement System (MOSERS), Missouri Department of Transportation and Highway Patrol Employees' Retirement System (MPERS), or another retirement system whose members are grandfathered for coverage under the plan by law.

(42) MCHCPid. An individual MCHCP member identifier used for member verification and validation.

(43) myMCHCP. A secure MCHCP member website that allows members to review coverage selections, verify covered dependents, make coverage changes, add/change email address, and access health plan websites.

(44) Medically necessary. Treatments, procedures, services, or supplies that the plan administrator determines, in the exercise of its discretion—

(A) Are expected to be of clear clinical benefit to the patient; and

(B) Are appropriate for the care and treatment of the injury or illness in question; and

(C) Conform to standards of good medical practice as supported by applicable medical and scientific literature. A treatment, procedure, service, or supply must meet all criteria listed above to be considered medically necessary and to be eligible for coverage under the plan. In addition, the fact that a provider has prescribed, ordered, or recommended a treatment, procedure, service, or supply does not, in itself, mean that it is medically necessary as defined above. Further, the treatment, procedure, service, or supply must not be specifically excluded from coverage under this plan.

(45) Medicare-approved amount. The fee Medicare sets as reasonable for a covered medical service. This is the amount a provider is paid by the member and Medicare for a service or supply. It may be less than the actual amount charged by a health care provider.

(46) Medicare assignment. When a health care provider agrees to accept the Medicare-approved amount as payment in full for claims.

(47) Member. Any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.

(48) Network. The facilities, providers, and suppliers the health insurer or plan has contracted with to provide health care services.

(49) Non-formulary. A drug not contained on the pharmacy benefit manager's list of covered drugs.

(50) Non-network. The facilities, providers, and suppliers the health plan does not contract with to provide health care services.

(51) Out-of-pocket maximum. The most the member will pay during a plan year before the plan begins to pay one hundred percent (100%) of the allowed amount. This limit never includes the member's premium, copayments, balance-billed charges, or health care services the plan does not cover.

(52) Participant. Shall have the same meaning as the term member defined herein (see member, section (47)).

(53) Plan. The program of health care benefits established by the board of trustees of the Missouri Consolidated Health Care Plan as authorized by state law.

(54) Plan administrator. The board of trustees of the Missouri Consolidated Health Care Plan, which is the sole fiduciary of the plan. The board has all discretionary authority to interpret its provisions and to control the operation and administration of the plan and whose decisions are final and binding on all parties.

(55) Plan year. The period of January 1 through December 31.

(56) Preferred provider organization (PPO). An arrangement with providers whereby discounted rates are given to plan members. Benefits are paid at a higher level when network providers are used.

(57) Premium. The monthly amount that must be paid for health insurance.

(58) Primary care physician (PCP). An internist, family/general practitioner, or pediatrician.

(59) Prior authorization. A decision by the plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called pre-authorization, prior approval, or precertification. The plan may require prior authorization for certain services before the member receives them, except in an emergency. Prior authorization is not a promise the plan will cover the cost. The provider must contact the appropriate plan administrator to request prior authorization.

(60) Provider. A physician, hospital, medical agency, specialist, or other duly licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-2.010(20). Other providers include but are not limited to:

(A) Audiologist (AUD or PhD);

(B) Certified Addiction Counselor for Substance Abuse (CAC);

(C) Certified Nurse Midwife (CNM)—when acting within the scope of his/her license in the state in which s/he practices and performing a service which would be payable under this plan when performed by a physician;

(D) Certified Social Worker or Masters in Social Work (MSW);

(E) Chiropractor;

(F) Licensed Clinical Social Worker;

(G) Licensed Professional Counselor (LPC);

(H) Licensed Psychologist (LP);

(I) Nurse Practitioner (NP);

(J) Physician Assistant (PA);

(K) Occupational Therapist;

(L) Physical Therapist;

(M) Speech Therapist;

(N) Registered Nurse Anesthetist (CRNA);

(O) Registered Nurse Practitioner (ARNP); or

(P) Therapist with a PhD or Master's Degree in Psychology or Counseling.

(61) Prudent layperson. An individual possessing an average knowledge of health and medicine.

(62) Qualified Medical Child Support Order (QMCSO). A child support order from a court of competent jurisdiction or state child care agency, which requires the plan to provide coverage for a dependent child or member if the plan normally provides coverage for dependent children.

(63) Retiree. A former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-2.020(2)(D) and is currently receiving a monthly

retirement benefit from a retirement system listed in such rule.

(64) Sound natural teeth. Teeth and/or tissue that is viable, functional, and free of disease. A sound natural tooth has no decay, fillings on no more than two (2) surfaces, no gum disease associated with bone loss, no history of root canal therapy, is not a dental implant, and functions normally in chewing and speech.

(65) Specialty care physician/specialist. A physician who is not a primary care physician and provides medical services to members concentrated in a specific medical area of expertise.

(66) Specialty medications. High cost drugs that treat chronic complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis.

(67) State. Missouri.

(68) Step therapy. Designed to encourage use of therapeutically-equivalent, lower-cost alternatives before using more expensive therapy. It is especially for people who take prescription drugs regularly to treat ongoing medical conditions and is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts.

(69) Subrogation. The substitution of one (1) "party" for another. Subrogation entitles the insurer to the rights and remedies that would otherwise belong to the insured (the subscriber) for a loss covered by the insurance policy. Subrogation allows the plan to stand in the place of the member and recover the money directly from the other insurer.

(70) Subscriber. The employee or member who elects coverage under the plan.

(71) Survivor. A dependent of a deceased vested active employee, terminated vested subscriber, vested long-term disability subscriber, or retiree.

(72) Terminated vested subscriber. A previous active employee eligible for a future retirement benefit from MOSERS, MPERS, or grandfathered for coverage under the plan by law.

(73) Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.

(74) Tobacco. Cigarettes, cigarette papers, clove cigarettes, cigars, smokeless tobacco, smoking tobacco, other form of tobacco products, or products made with tobacco substitute containing nicotine.

(75) Tobacco-free. A member has not used a tobacco product in at least the previous three (3) months and plans to remain tobacco-free in the future.

(76) Usual, customary, and reasonable. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

(77) Vendor. The current applicable third-party administrators of MCHCP benefits.

(78) Vested subscriber. An active employee eligible for coverage under the plan and eligible for future benefits from MOSERS, MPERS, or grandfathered for coverage under the plan by law.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director rescinds a rule as follows:

22 CSR 10-2.020 General Membership Provisions **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2719–2720). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

22 CSR 10-2.020 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2720–2729). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received thirteen (13) comments on the proposed rule.

COMMENT #1: MCHCP staff commented that, under part (2)(B)1.A.(I) and paragraphs (3)(B)1. and (3)(C)1., clarification is needed that these sections apply to active employees, not all employees.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under part (2)(B)1.A.(I) and paragraphs (3)(B)1. and (3)(C)1. that those sections only apply to active employees and not to all employees.

COMMENT #2: MCHCP staff commented that, under subpart (2)(B)1.B.(I)(e), clarification is needed that foster children are still eligible for coverage if the foster child relationship was in effect between the child and subscriber or spouse when the child aged out.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subpart (2)(B)1.B.(I)(e) that foster children are still eligible for coverage if the foster child relationship was in effect between the child and subscriber or spouse when the child was aged out.

COMMENT #3: MCHCP staff commented that, under part (2)(B)1.B.(I), clarification is needed that a child under the age twenty-six (26) who is a state employee may be covered as a dependent of a state employee.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under part (2)(B)1.B.(I) that a child under the age twenty-six (26) who is a state employee may be covered as a dependent of a state employee.

COMMENT #4: MCHCP staff commented that, under subparagraph (2)(D)1.C., clarification is needed to reword the sentence to clearly explain how a retiree's spouse who is a state employee may transfer coverage.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, subparagraph (2)(D)1.C. was reworded to clearly explain how a retiree's spouse who is a state employee may transfer coverage.

COMMENT #5: MCHCP staff commented that, under paragraph (2)(D)4., clarification is needed that a survivor of a terminated vested subscriber may continue coverage as a dependent if they had MCHCP coverage as a dependent at the time of the employee's death and that this section does not apply to a long-term disability survivor.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (2)(D)4. that a survivor of a terminated vested subscriber may continue coverage as a dependent if he/she had MCHCP coverage as a dependent at the time of the employee's death, and that this section does not apply to a long-term disability survivor.

COMMENT #6: MCHCP staff commented that, under subparagraph (2)(D)5.A., clarification is needed that a terminated vested employee may transfer to a spouse's coverage, not a vested employee.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subparagraph (2)(D)5.A. that a terminated vested employee may transfer to a spouse's coverage and that an active vested employee could not.

COMMENT #7: MCHCP staff commented that, under paragraph (3)(C)4., clarification is needed that if a subscriber's spouse receives a court order for coverage of a dependent, the subscriber may enroll that dependent.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (3)(C)4. that if a subscriber's spouse receives a court order for coverage of a dependent, the subscriber may enroll that dependent.

COMMENT #8: MCHCP staff commented that, under paragraph (3)(C)5., clarification is needed that a survivor can add a dependent due to placement of a child.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (3)(C)5. that a survivor can add a dependent due to placement of a child.

COMMENT #9: MCHCP staff commented that, under paragraph (4)(A)3., clarification is needed regarding the effective dates for adoption, legal custody, and foster care.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (4)(A)3. regarding the effective dates for adoption, legal custody, and foster care.

COMMENT #10: MCHCP staff commented that, under paragraph (4)(A)8., clarification is needed when coverage is effective under a qualified medical child support order.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (4)(A)8. regarding when coverage is effective under a qualified medical child support order.

COMMENT #11: MCHCP staff commented that, under paragraph (5)(A)3., clarification is needed for acceptable proof of eligibility for legal custody.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (5)(A)3. regarding acceptable proof of eligibility for legal custody.

COMMENT #12: MCHCP staff commented that, under paragraph (9)(B)2., clarification is needed that when an employee cancels coverage, coverage ends on the last day of the month in which MCHCP receives the cancellation.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (9)(B)2. that when an employee cancels coverage, coverage ends on the last day of the month in which MCHCP receives the cancellation.

COMMENT #13: MCHCP staff commented that, under paragraph (10)(A)8., clarification is needed that vision is a benefit eligible to continue for an employee on military leave.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (10)(A)8. that vision was included as a benefit eligible to continue for an employee on military leave.

22 CSR 10-2.020 General Membership Provisions

(2) Eligibility Requirements.
(B) Dependent Eligibility Requirements.
1. An employee who is not retired may enroll eligible dependents as long as the employee is also enrolled. Eligible dependents include:
A. Spouse.
(I) If both spouses are active state employees covered by MCHCP, each spouse must enroll separately.
(II) State employees eligible for coverage under the Missouri Department of Transportation, Department of Conservation, or the Highway Patrol medical plans may not enroll as a spouse under MCHCP.
(III) A state retiree may enroll as a spouse under an employee's coverage or elect coverage as a retiree.
(IV) If one (1) spouse is a state employee with MCHCP benefits and the other is a public entity employee with MCHCP benefits, each spouse may enroll under his or her employer's plan or together under one (1) employer's plan. The spouses cannot have coverage in both places; and
B. Children.
(I) Children may be covered through the end of the month in which they turn twenty-six (26), if they meet one (1) of the following criteria:
(a) Natural child of subscriber or spouse;
(b) Legally-adopted child of subscriber or spouse;
(c) Child legally placed for adoption of subscriber or spouse;
(d) Stepchild of subscriber or spouse;
(e) Foster child of subscriber or spouse. Such child will continue to be considered a dependent child after the foster child relationship ends by operation of law when the child ages out if the foster child relationship between the subscriber or spouse and the child was in effect the day before the child ages out;
(f) Grandchild for whom the covered subscriber or covered spouse has legal guardianship or legal custody;
(g) A child for whom the subscriber or spouse is the court-ordered legal guardian under a guardianship of a minor. Such child will continue to be considered a dependent child after the guardianship ends by operation of law when the child becomes eighteen (18) years of age if the guardianship of a minor relationship between the subscriber or spouse and the child was in effect the day before the child became eighteen (18) years of age;

(h) Newborn of a subscriber or a covered dependent;

(i) Child for whom the subscriber or covered spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO);

(j) Child who is twenty-six (26) or older and is permanently disabled in accordance with subsection (5)(C), only if such child was an MCHCP member the day before the child turned twenty-six (26); or

(k) A child under the age of twenty-six (26) who is a state employee may be covered as a dependent of a state employee.

(II) A child may only be covered by one (1) parent if his/her parents are married and are both covered under an MCHCP medical plan.

(III) A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. MCHCP will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim first. The second claim for the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for the longest period of time.

(D) Retiree, Survivor, Vested, Terminated Vested, and Long-Term Disability Employee; Elected State Officials and their Employee; and Dependent Eligibility Requirements.

1. An employee may participate in an MCHCP plan when s/he retires if s/he is eligible to receive a monthly retirement benefit from either MOSERS or from PSRS for state employment.

A. To enroll or continue coverage at retirement, the employee and his/her dependents must provide all of the following:

(I) Submit a completed enrollment form within thirty-one (31) days of retirement date. Coverage is effective on retirement date;

(II) Submit a completed enrollment form thirty-one (31) days before retirement date to have his/her first month's retirement premium deducted and divided between his/her last two (2) payrolls and the option to pre-pay premiums through the cafeteria plan;

(III) Submit proof of prior coverage and proof of eligibility for dependents if s/he and his/her dependents choose to enroll in an MCHCP plan at retirement and have had other insurance coverage for six (6) months immediately prior to his/her retirement; and

(IV) Submit a statement from PSRS that indicates the effective date of the subscriber's retirement if the subscriber is a PSRS retiree.

B. Employees may continue coverage on their eligible dependents into retirement.

C. If the retired employee's spouse is a state employee (active or retired), the retired employee's spouse may transfer to coverage under the plan in which his/her spouse is enrolled or from his/her spouse's coverage to his/her own coverage at any time as long as both spouses are eligible for MCHCP coverage and their coverage is continuous.

2. An enrolled terminated vested or long-term disability employee and his/her dependents will have continuous coverage into retirement unless the member submits a termination form.

3. A survivor of an active employee who is a vested subscriber and his/her dependents or a survivor of a vested subscriber who was receiving long-term disability benefits and his/her dependents from MOSERS or PSRS may continue coverage if the survivor had—

A. Coverage through MCHCP at the time of the subscriber's death; or

B. Other health insurance for the six (6) months immediately prior to employee's death. Proof of eligibility for each dependent, proof of prior group coverage (letter from previous insurance carrier or former employer with dates of effective coverage and a list of dependents covered is required).

4. A survivor of a retired employee or terminated vested subscriber may continue coverage if the survivor had MCHCP coverage as a dependent at the time of the employee's death.

5. An employee may participate in an MCHCP plan when his/her employment with the state terminates if s/he is a vested member and is eligible for a future benefit from the MOSERS or PSRS as a state employee when s/he reaches retirement age. The employee must elect to continue coverage within thirty-one (31) days from the last day of the month in which his/her employment is terminated.

A. If a terminated vested employee's spouse is a state employee (active or retired), the terminated vested employee may transfer coverage under the plan in which his/her spouse is enrolled.

B. The employee and his/her dependents must meet one (1) of the following requirements to participate in an MCHCP plan as a terminated vested employee:

(I) Coverage through MCHCP since the effective date of the last open enrollment period; or

(II) Proof of prior group coverage for the six (6) months immediately prior to the termination of state employment. Proof of prior group coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of dependents covered is required).

6. If a vested employee does not elect coverage, or if s/he cancels his/her coverage or dependent coverage, the vested employee and his/her dependents cannot enroll at a later date. The vested employee may continue coverage under the provisions of Consolidated Omnibus Budget Reconciliation Act (COBRA).

7. If any retired, survivor, terminated vested, or long-term disability employee, or his/her dependents who are eligible for coverage, elect not to be continuously covered from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage except as noted in paragraph (2)(D)8.

8. A long-term disability employee must be eligible for long-term disability benefits from MOSERS or PSRS and have had coverage since the effective date of the last open enrollment period.

A. The employee may continue coverage on his/her dependents or add new dependents due to a life event.

B. If the employee becomes ineligible for disability benefits, the employee and his/her dependents may continue coverage as applicable, as a terminated vested, retired, or COBRA subscriber, unless the employee returns to active state employment.

C. If coverage was not elected through MCHCP before the date of disability, the employee and his/her dependents may enroll as long as the employee and his/her dependents have had other health insurance coverage for the six (6) months immediately prior to the employee's disability. Proof of eligibility for each dependent and proof of prior group coverage (letter from previous insurance carrier or former employer with dates of effective coverage and a list of dependents covered is required).

D. If coverage was not maintained while on disability, the employee and his/her dependents may enroll on the date the employee is eligible for retirement benefits as long as the employee and his/her dependents have had other health insurance coverage for the six (6) months immediately prior to the employee's retirement. Proof of eligibility for each dependent and proof of prior group coverage (letter from previous insurance carrier or former employer with dates of effective coverage and a list of dependents covered is required).

E. If the employee's spouse is a state employee (active or retired), s/he may transfer coverage under the plan in which his/her spouse is enrolled.

F. If the employee wishes to be covered individually at a later date, s/he can make the change, as long as coverage is continuous.

G. If the employee returns to work, the employee and his/her state employee spouse must be covered individually.

9. A retiree, survivor, vested employee, or long-term disability employee and/or his/her dependents may continue dental and/or vision coverage into retirement without medical coverage.

10. An elected state official or his/her employees may continue coverage in an MCHCP plan if s/he is a member of the General Assembly, a state official holding a statewide office, or employed by a member of the General Assembly or a state official and his/her employment terminates because the state official or member of the General Assembly ceases to hold elected office. The elected state official or his/her employees must elect to continue coverage within thirty-one (31) days from the last day of the month in which his/her employment is terminated. The member will not later be eligible if s/he discontinues coverage at some future time.

(3) Enrollment Procedures.

(B) Open Enrollment.

1. An active employee may elect coverage and/or change coverage levels during the annual open enrollment period if one (1) of the following occurred:

A. Waived his/her right to insurance when first eligible;

B. Did not enroll eligible dependents when first eligible; or

C. Dropped his/her or dependent coverage during the year.

2. A retiree, terminated vested, long-term disability, or survivor may change from one (1) medical plan to another during open enrollment but cannot add a dependent. If a retiree, terminated vested, long-term disability, or survivor subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in a plan during open enrollment.

(C) Special Enrollment Periods.

1. An active employee may apply for coverage for himself/herself or for his/her dependents if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of adopted children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. An employee and his/her dependents may enroll within sixty (60) days if s/he involuntarily loses employer-sponsored coverage under one (1) of the following circumstances:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. A retiree, terminated vested, long-term disability, or survivor may apply for dependent coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of adopted children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. A retiree, terminated vested, long-term disability, or survivor may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. MO HealthNet or Medicaid status loss. If an employee who is not retired, terminated, vested, long-term disability, survivor, or his/her dependent loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss.

4. Qualified Medical Child Support Order. If a subscriber or subscriber's spouse receives a court order stating s/he is responsible for coverage of dependent, the subscriber may enroll the dependent in an MCHCP plan within sixty (60) days of the court order.

5. A survivor must submit a survivor enrollment form and a copy of the death certificate within thirty-one (31) days of the first day of the month after the death of the employee.

A. If the survivor does not elect coverage within thirty-one (31) days of the first day of the month after the death of the employee, s/he cannot enroll at a later date.

B. If the survivor marries, has a child, adopts a child, or a child is placed with survivor, the dependent must be added within thirty-one (31) days of birth, adoption, placement, or marriage.

C. If eligible dependent(s) are not enrolled when first eligible, they cannot be enrolled at a later date.

6. If an active employee has elected coverage as a dependent of another MCHCP subscriber as allowed by these rules, and the subscriber dies before coverage as a dependent goes into effect, the active employee may elect coverage as a subscriber within thirty-one (31) days of the date of death.

(4) Effective Date Provision. In no circumstances can the effective date be before the eligibility date. The effective date of coverage shall be determined, subject to the effective date provisions as follows:

(A) Employee and Dependent Effective Dates.

1. A new employee and his/her dependents' coverage begins on the first day of the month after enrollment through SEBES.

2. Except at initial employment, an employee and his/her eligible dependents' effective date of coverage is the first of the month coinciding with or after the eligibility date. The effective date of coverage cannot be prior to the date of receipt of the enrollment by MCHCP, except for newborns.

3. The effective date of coverage for a life event shall be as follows:

A. If enrollment by an employee is made before a wedding date, spouse's coverage becomes effective on the wedding date. The monthly premium is not prorated;

B. If enrollment by an employee is made within thirty-one (31) days of a wedding date, spouse's coverage becomes effective the first of the month coinciding with or after receipt of the enrollment form and proof of eligibility;

C. If enrollment by a subscriber is made for a newborn of a member, the effective date for the newborn is the birth date. If enrollment is made by an employee due to the birth of a newborn of the employee, the effective date for the employee and newborn is the first of the month coinciding with or after enrollment is received;

D. If enrollment by an employee is made prior to the eligibility date for an adoption or placement of children, coverage becomes effective on the eligibility date;

E. If enrollment by an employee is made within thirty-one (31) days after the eligibility date, for an adoption, or placement of children, coverage becomes effective the first day of the calendar month coinciding with or after the date the enrollment is received;

F. Legal guardianship and legal custody. If enrollment by an employee is made due to legal guardianship or legal custody of a dependent within thirty-one (31) days of guardianship or custody effective date, the effective date for coverage is the first day of the calendar month coinciding with or after the date the enrollment is received; or

G. Foster care. If enrollment by an employee is made due to placement of a foster child in the employee's care within thirty-one (31) days of placement, the effective date for coverage is the first day of the calendar month coinciding with or after the date the enrollment is received.

4. An employee and his/her eligible dependent(s) who elect coverage and/or change coverage levels during open enrollment shall have an effective date of January 1 of the following year.

5. An employee who transferred from a state department with coverage under another medical care plan into a state department

covered by this plan, and his/her eligible dependent(s) who were covered by the other medical plan, will have coverage effective immediately if an enrollment form is submitted within thirty-one (31) days of transfer.

6. An employee who terminates all employment with the state (not simply moves from one (1) agency to another) and is rehired as a new state employee before termination of coverage, and his/her eligible dependent(s) who were covered by the plan, will have coverage effective immediately.

A. If the employee's coverage is continuous, s/he cannot increase his/her level of coverage or change plans.

B. If the employee requests coverage within the first thirty-one (31) days of hire date to begin the first of the month after his/her hire date, s/he can make changes to his/her coverage.

C. If an employee cancels coverage, s/he cannot enroll until the next open enrollment for coverage effective the following January.

7. An employee and his/her eligible dependent(s) who transfers from another state agency with MCHCP benefits to an MCHCP state agency will be transferred by the former state agency's human resource or payroll representative through eMCHCP to the new state agency. The employee must inform the former agency of the transfer in lieu of a termination. If the employee's coverage is continuous, s/he cannot increase his/her level of coverage or change plans.

8. Coverage is effective for a dependent child the first of the month coinciding with or after the Qualified Medical Child Support Order is received by the plan or date specified by the court.

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents. Enrollment of a dependent is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, a letter will be sent requesting it. Except for open enrollment, documentation must be received within thirty-one (31) days of the letter date, or eligible dependent(s) will not be added. MCHCP reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by MCHCP, coverage for the applicable dependent will terminate or never take effect. If enrolling dependents during open enrollment, proof of eligibility must be received by November 20, or eligible dependents will not be added for coverage effective the following January 1.

(A) Addition of Dependents. Required documentation should accompany the enrollment for coverage, except when adding a newborn. Failure to provide acceptable documentation with the enrollment will result in the dependent not having coverage until such proof is received, subject to the following:

1. If proof of eligibility is not received with the enrollment, such proof will be requested by letter sent to the subscriber. The enrollment will not be processed until after proof of eligibility is received. Documentation shall be received no later than thirty-one (31) days from the date of the letter requesting such proof. If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility. Failure to provide the required documentation in a timely manner will result in the dependent being ineligible for coverage until the next open enrollment period; and

2. Coverage is provided for a newborn of a member from the moment of birth. The member must notify MCHCP of the birth verbally or in writing within thirty-one (31) days of the birth date. The plan will notify the member of the steps to continue coverage. The member is allowed an additional ten (10) days from the date of the plan notice to return the enrollment form. Coverage will not continue unless the enrollment form is received within thirty-one (31) days of the birth date or ten (10) days from the date of the notice, whichever is later. Newborn proof of eligibility must be submitted within ninety (90) days of the date of birth. If proof of eligibility is not received, coverage will terminate on day ninety-one (91) from the birth date;

3. Acceptable forms of proof of eligibility are included in the following chart:

Circumstance	Documentation
Birth of dependent(s)	Government-issued birth certificate or other government-issued or legally-certified proof of eligibility listing subscriber as parent and newborn's full name and birth date
Addition of step-child(ren)	Marriage license to biological or legal parent/guardian of child(ren); and government-issued birth certificate or other government-issued or legally-certified proof of eligibility for child(ren) that names the subscriber's spouse as a parent or guardian and child's full name and birth date
Addition of foster child(ren)	Placement papers in subscriber's care
Adoption of dependent(s)	Adoption papers; Placement papers; or Filed petition for adoption; and Lists subscriber as adoptive parent
Legal guardianship or legal custody of dependent(s)	Court-documented guardianship or custody papers listing member as guardian or custodian (Power of Attorney is not acceptable)
Newborn of covered dependent	Government-issued birth certificate or legally-certified proof of eligibility for newborn listing covered dependent as parent with newborn's full name and birth date
Marriage	Marriage license or certificate recognized by Missouri law
Divorce	Final divorce decree; or Notarized letter from spouse stating s/he is agreeable to termination of coverage pending divorce or legal separation
Death	Death certificate
Loss of MO HealthNet or Medicaid	Letter from MO HealthNet or Medicaid stating who is covered and the date coverage terminates
MO HealthNet Premium Assistance	Letter from MO HealthNet or Medicaid stating member is eligible for the premium assistance program
Qualified Medical Child Support Order	Qualified Medical Child Support Order
Prior Group Coverage	Letter from previous insurance carrier or former employer stating date coverage terminated, reason for coverage termination, and list of dependents covered

(9) Continuation of Coverage.

(B) Leave of Absence—Family and Medical Leave Act (FMLA).

1. An employee must be approved for a leave of absence under the FMLA and meet the requirements and guidelines set forth by FMLA and his/her employing agency for his/her employer to continue to pay the monthly contribution toward the employee's and his/her dependents' coverage. Coverage is continuous unless the employee chooses to cancel coverage.

2. If the employee cancels coverage, coverage ends on the last day of the month in which MCHCP received the cancellation.

3. If the employee cancels coverage, the employee must submit a completed form within thirty-one (31) days of his/her return to work.

4. If the employee is unable to return to work after his/her FMLA leave ends, s/he may elect leave of absence coverage or suspend his/her coverage. If coverage is suspended at that time, s/he can enroll within thirty-one (31) days of his/her return to work.

(10) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) Eligibility. In accordance with COBRA, eligible employees and their dependents may temporarily continue their coverage when coverage under the plan would otherwise end. Coverage is identical to the coverage provided under MCHCP to similarly-situated employees and family members. If members cancel COBRA coverage, they cannot enroll at a later date.

1. Employees voluntarily or involuntarily terminating employment (for reasons other than gross misconduct) or receiving a reduction in the number of hours of employment may continue coverage for themselves and their covered dependent(s) for eighteen (18) months at their own expense.

2. If a subscriber marries, has a child, or adopts a child while on COBRA coverage, eligible dependents can be added to the subscriber's plan upon notification to MCHCP. The subscriber may also add eligible dependents during open enrollment.

3. Dependents may continue coverage for up to thirty-six (36) months at their own expense if the covered employee becomes eligible for Medicare.

4. A surviving spouse and dependents, not normally eligible for continued coverage, may elect coverage for up to thirty-six (36)

months at their own expense.

5. A divorced spouse and dependents may continue coverage at their own expense for up to thirty-six (36) months.

6. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) expense.

7. If the Social Security Administration determines a COBRA member is disabled within the first sixty (60) days of coverage, the member may continue coverage for up to twenty-nine (29) months.

8. An employee who is on military leave is eligible for continued coverage for medical, vision, and dental care for the lesser of: a) twenty-four (24) months beginning on the date the leave begins; or b) the day after the date the employee fails to apply for or return to their position of employment following leave.

9. If the eligible member has Medicare prior to becoming eligible for COBRA coverage, the member is entitled to coverage under both.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.030 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2730–2733). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received one (1) comment on the proposed amendment.

COMMENT: MCHCP staff commented that clarification is needed on how the MCHCP contribution for retirees is calculated.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment the calculation for the MCHCP contribution was clarified.

22 CSR 10-2.030 Contributions

(3) The Missouri Consolidated Health Care Plan (MCHCP) contribution toward the retiree premium is based on creditable years of service at retirement with the state. It is calculated by using the number of full creditable years of service at retirement as reported to MCHCP by Missouri State Employees' Retirement System (MOSERS) or Public School Retirement System (PSRS) multiplied by two and one half percent (2.5%). The resulting product shall be capped at sixty-five percent (65%). For Medicare retirees, the computed percentage is multiplied by the PPO 600 Plan total premium. For non-Medicare retirees, the computed percentage is multiplied by the PPO 600 Plan total premium with the tobacco-free incentive and the wellness incentive. The resulting product is the MCHCP contribution, which shall be subtracted from the total premium of the plan chosen by the retiree. The difference is the amount of the retiree contribution toward the total premium.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
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ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.045 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2734–2735). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received one (1) comment on the proposed amendment.

COMMENT: MCHCP staff commented that it is not clear that cardiac rehabilitation and pulmonary rehabilitation are both eligible for thirty-six (36) visits within a twelve- (12-) week period.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, this rule was amended to clarify that cardiac rehabilitation and pulmonary rehabilitation are both eligible for thirty-six (36) visits within a twelve- (12-) week period.

22 CSR 10-2.045 Plan Utilization Review Policy

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) Prior Authorization of Services—The claims administrator must authorize some services in advance. Without prior authorization, any claim that requires prior authorization will not be covered. Members who have another primary carrier, including Medicare, are not subject to this provision. Prior authorization does not verify eligibility or payment. Prior authorizations based on a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition will not be covered.

1. The following medical services are subject to prior authorization:

A. Ambulance services for non-emergent use whether air or ground;

B. Anesthesia and hospital charges for dental care for children younger than five (5), the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;

C. Applied behavior analysis for autism;

D. Auditory brainstem implant (ABI);

E. Bariatric procedures;

F. Cardiac rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

G. Chiropractic services after twenty-six (26) visits annually;

H. Cochlear implant device;

I. Chelation therapy;

J. Dental care to reduce trauma and restorative services when the result of accidental injury;

K. Durable medical equipment (DME) over one thousand five hundred dollars ($1,500) or DME rentals over five hundred dollars ($500) per month;

L. Genetic testing or counseling;

M. Home health care and palliative services;

N. Hospice care;

O. Hospital inpatient services except for observation stays;

P. Maternity coverage for maternity hospital stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery;

Q. Nutritional counseling after three (3) sessions annually;

R. Orthotics over one thousand dollars ($1,000);

S. Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per incident;

T. Procedures with codes ending in "T";

U. Prostheses over one thousand dollars ($1,000);

V. Pulmonary rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

W. Skilled nursing facility;

X. Surgery (outpatient)—The following outpatient surgical procedures: cornea transplant, potential cosmetic surgery, sleep apnea surgery, implantable stimulators, stimulators for bone growth, surgeries with procedure codes ending in "T" (temporary codes used for data collection, experimental, investigational, or unproven surgeries), spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams); and

Y. Transplants including requests related to covered travel and lodging.

2. The following pharmacy services are subject to prior authorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications;

C. Medications that may be prescribed for several conditions, including some for which treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. The cost of the medication exceeds nine thousand nine hundred ninety-nine dollars and ninety-nine cents ($9,999.99) at retail pharmacy, one thousand four hundred ninety-nine dollars and ninety-nine cents ($1,499.99) at mail order, and one hundred forty-nine dollars and ninety-nine cents ($149.99) for compound medications.

3. Prior authorization time frames.

A. A benefit determination for non-urgent prior authorization requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen- (15-) calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least forty-five (45) calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent prior authorization requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

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ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.051 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2735–2738). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received two (2) comments on the proposed amendment.

COMMENT #1: MCHCP staff commented that the family out-of-pocket maximum is the combination of family member applicable charges, not the combination of family member out-of-pocket maximums.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the rule now correctly states that the family out-of-pocket maximum is the combination of family member applicable charges.

COMMENT #2: MCHCP staff commented that the benefit coverage for in-hospital days that overlap current and upcoming plan years is unclear.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the rule clarifies the benefit coverage for in-hospital days that overlap current and upcoming plan years.

22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(B) The family out-of-pocket maximum is an aggregate of applicable charges received by all covered members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

(9) For a member who is inpatient on the last calendar day of a plan year and remains inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

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ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.052 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2739–2741). Those sections with changes are

reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received two (2) comments on the proposed amendment.

COMMENT #1: MCHCP staff commented that the family out-of-pocket maximum is the combination of family member applicable charges, not the combination of family member out-of-pocket maximums.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the rule now correctly states that the family out-of-pocket maximum is the combination of family member applicable charges.

COMMENT #2: MCHCP staff commented that the benefit coverage for in-hospital days that overlap current and upcoming plan years is unclear.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the rule clarifies the benefit coverage for in-hospital days that overlap current and upcoming plan years.

22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges

(3) Out-of-pocket maximum—the maximum amount payable by the member before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(B) The family out-of-pocket maximum is an aggregate of applicable charges received by all covered members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

(8) For a member who is inpatient on the last calendar day of a plan year and remains inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

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ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.053 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2742–2745). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received one (1) comment on the proposed amendment.

COMMENT: MCHCP staff commented that the benefit coverage for in-hospital days that overlap current and upcoming plan years is unclear.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the rule clarifies the benefit coverage for in-hospital days that overlap current and upcoming plan years.

22 CSR 10-2.053 High Deductible Health Plan Benefit Provisions and Covered Charges

(10) For a member who is inpatient on the last calendar day of a plan year and remains inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

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ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.054 Medicare Supplement Plan Benefit Provisions and Covered Charges **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2746–2748). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

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ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director rescinds a rule as follows:

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2749). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

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ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

22 CSR 10-2.055 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2749–2755). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received one (1) comment on the proposed rule.

COMMENT: MCHCP staff commented that clarification is needed that preventive colorectal screening will be covered in compliance with federal law.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, this rule was amended to clarify that preventive colorectal screening will be covered in compliance with federal law.

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges

(2) Covered Charges Applicable to the PPO 300 Plan, PPO 600 Plan, and HDHP.

(F) Plan benefits for the PPO 300 Plan, PPO 600 Plan, and HDHP are as follows:

1. Allergy testing and immunotherapy. Allergy testing and allergy immunotherapy is covered for members with clinically-significant allergic symptoms. No coverage for non-physician allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning;

2. Ambulance service. Ambulance transport services involve the use of specially-designed and equipped vehicles to transport ill or injured individuals. Ambulance transportation by ground to the nearest appropriate facility is covered when medically necessary and other means of transportation would be contraindicated. This can include emergent and non-emergent, yet medically necessary situations. Ambulance transportation by air to the nearest appropriate facility is covered when medically necessary and only if the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate. Medical necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. Use of air ambulance or medical helicopter service from any country returning to the U.S. is excluded;

3. Applied behavior analysis for autism. For children younger than age nineteen (19), the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of observation, measurement, and functional analysis of the relationship between environment and behavior are covered with a forty thousand dollar ($40,000) annual limit. The annual limit may be exceeded, upon prior authorization by the medical plan, if services beyond the annual limit are medically necessary;

4. Bariatric surgery. Open or laparoscopic Roux-en-Y gastric bypass (RYGB), open or laparoscopic sleeve gastrectomy (SG), open or laparoscopic biliopancreatic diversion (BPD) with or without duodenal switch (DS), or laparoscopic adjustable silicone gastric banding (LASGB) are covered when specific health criteria are met;

5. Birth control devices and injections. Birth control is any method used to prevent pregnancy. Food and Drug Administration (FDA)-approved birth control devices and injections are covered when administered in a physician's office;

6. Cancer trials. Coverage for routine patient care costs incurred as the result of a Phase II, III, or IV clinical trial that is approved by an appropriate entity and is undertaken for the purposes of the prevention, early detection, or treatment of cancer. Coverage includes routine patient care costs incurred for drugs and devices that have been approved for sale by the FDA, regardless of whether they have been approved by the FDA for use in treating the patient's condition. Coverage includes reasonable and medically-necessary services needed to administer the drug or use the device under evaluation in the clinical trial;

7. Cardiac rehabilitation. Coverage for an electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) as medically necessary when it is individually prescribed by a physician and a formal exercise stress test is completed following the event and prior to the initiation of the program. Up to thirty-six (36) visits are covered within a twelve- (12-) week period per incident. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

8. Chelation therapy. Chelation therapy agents covered for FDA-approved indication(s) and associated condition(s). Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit are explicitly excluded under MCHCP's benefit plan. Therefore, treatment of metal toxicity that occurs as a result of occupational exposure is not covered;

9. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered. Up to twenty-six (26) visits covered annually. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

10. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation is covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device.

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

11. Dental care/accidental injury. Treatment to reduce trauma and restorative services only when the result of accidental injury to sound, natural teeth and tissue that are viable, functional, and free of disease. Oral surgery is covered when medically necessary as a direct result of injury, tumors, or cysts. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5), the severely disabled, or a person with a medical or behavioral condition that requires hospitalization. General anesthesia is covered when dental care is provided in a participating or non-participating hospital or surgical center;

12. Durable medical equipment (DME)/medically-necessary disposable supplies. DME is covered when the equipment is ordered by a physician to treat an injury or sickness (illness). DME includes, but is not limited to, insulin pumps, oxygen, augmentative communication devices, and manual and powered mobility devices. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, colostomy and ureterostomy bags and prescription compression stockings, are covered. Prescription compression stockings are limited to two (2) pairs or four (4) individual stockings per plan year. Non-reusable disposable supplies, including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinence pads, irrigating kits, pressure leotards, surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are

not covered. Repair and replacement of DME is covered when—

A. Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

B. Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

C. The physician provides documentation that the condition of the member changes or if growth-related;

13. Emergency room services. An emergency medical condition is defined as the manifestation of acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child. If admitted to hospital, may be required to transfer to network facility for maximum benefit;

14. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement immediately following cataract surgery;

15. Foot care (trimming of nails, corns, or calluses). Foot care services are covered when associated with systemic conditions that are significant enough to result in severe circulatory insufficiency and/or areas of desensitization in the lower extremities and service is provided by a qualified health provider. Foot care is considered routine in nature and not medically necessary in the absence of systemic disease that has resulted in severe circulatory insufficiency and/or areas of desensitization in the lower extremities;

16. Genetic counseling. The National Society of Genetic Counselors defines genetic counseling as: "The process of helping people understand and adapt to the medical, psychological, and familial implications of genetic contributions to disease." Pre-test and post-test genetic counseling with a physician or a licensed or certified genetic counselor covered as medically necessary for an individual recommended for covered heritable genetic testing;

17. Genetic testing. No coverage for testing based on family history alone. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

A. The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

B. The result of the test will directly impact the treatment being delivered to the member;

C. The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

D. After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain;

18. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

19. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars ($200), and the lifetime maximum is three thousand two hundred dollars ($3,200);

20. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

A. Conventional: one thousand dollars ($1,000).

B. Programmable: two thousand dollars ($2,000).

C. Digital: two thousand five hundred dollars ($2,500).

D. Bone Anchored Hearing Aid (BAHA): three thousand five hundred dollars ($3,500);

21. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by physician;

22. Home health care. Skilled home health care is covered for members who are homebound because of illness or injury (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care); services must be performed by a registered nurse or licensed practical (vocational) nurse, licensed therapist, or a registered dietitian;

23. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care which is directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week;

24. Hospital (includes inpatient, outpatient, and surgical centers). The following benefits are covered:

A. Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

B. Intensive care unit room and board;

C. Surgery, therapies, and ancillary services—

(I) Cornea transplant-travel and lodging are not covered for cornea transplant;

(II) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(III) Sterilization for the purpose of birth control is covered;

(IV) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(V) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19); and

(VI) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

D. Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(I) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(II) The member's mental health disorder must be treatable in an inpatient facility;

(III) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association *Diagnostic and Statistical Manual* (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region; and

(IV) The attending physician must be a psychiatrist. If the admitting physician is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board eligible or board certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending physician must meet the

requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

E. Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multi-disciplinary services not otherwise offered in an outpatient setting. The treatment program is generally a minimum of twenty (20) hours of scheduled programming extended over a minimum of five (5) days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment;

F. Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and

G. Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(I) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(II) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(III) A state-licensed psychologist;

(IV) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(V) Licensed professional counselor;

25. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition;

26. Maternity coverage. Prenatal and postnatal care is covered. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after normal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post-discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home. During a hospital admission for delivery, only the mother's claims will be subject to a deductible and coinsurance when the mother is covered under the plan. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or transfer to another facility;

27. Nutritional counseling. Individualized nutritional evaluation and counseling as for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian), up to three (3) sessions annually with a registered dietitian, with physician order. The maximum may be exceeded for an additional three (3) sessions, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary. Does not cover individualized nutritional evaluation and counseling for the management of conditions where appropriate diet and eating habits have not been proven to be essential to the overall treatment program because they are not considered to be medically necessary. Conditions for which nutritional evaluation and counseling are not considered to be medically necessary include, but are not limited to, the following:

A. Attention-deficit/hyperactivity disorder (ADHD);

B. Chronic fatigue syndrome (CFS);

C. Idiopathic environmental intolerance (IEI); or

D. Asthma;

28. Nutritional therapy. Nutritional therapy is covered when it is the sole source of nutrition or a significant percentage of the daily caloric intake; is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder; is prescribed by a physician; is necessary to sustain life or health; and requires ongoing evaluation and management by a licensed healthcare provider;

29. Office visit. Member encounter with a health care or mental health care/chemical dependency provider in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan being provided, including non-specialty infusions and injections. Specialty injections NEUPOGEN® (Filgrastim) and Neulasta® (Pegfilgrastim) are covered under the medical plan when the treating physician deems it medically necessary to be administered in the physician's office rather than as a self-injectable;

30. Orthotics. Therapeutic shoes, inserts, and/or modifications to therapeutic shoes; thoracic-lumbar-sacral orthosis, lumbar orthosis, or lumbar-sacral orthosis; helmets—covered when cranial protection is required due to a documented medical condition that makes the recipient susceptible to injury during activities of daily living; cranial orthosis for plagiocephaly, cervical orthosis, hip orthosis, knee orthosis, and ankle-foot/knee-ankle-foot orthoses (AFO) are covered;

31. Physical, speech, and occupational therapy and rehabilitation services (outpatient). Up to sixty (60) combined visits allowed per incident if showing significant improvement. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

32. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Annual physical exams (well man, woman, and child) and routine lab and X-ray services ordered as part of the annual exam. One (1) exam per calendar year is covered. For benefits to be covered as preventive, including X-rays and lab services, they must be coded by your physician as routine, without indication of an injury or illness.

F. Cancer screenings—

(I) Mammograms—one (1) exam per year, no age limit;

(II) Pap smears—one (1) per year, no age limit;

(III) Prostate—one (1) per year, no age limit; and

(IV) Colorectal Screening—One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema per year covered as preventive even if the primary diagnosis is not a preventive code provided a preventive code is included in connection with the screening. Virtual colonoscopy covered as diagnostic only. Additional colorectal screenings covered as diagnostic unless otherwise specified.

G. Flu vaccination (influenza)—The seasonal flu vaccine is covered under the preventive care benefit. When shot is obtained out of network, member must submit a receipt and a Non-Network Flu Shot Reimbursement form to medical plan to receive up to twenty-five dollars ($25). Multiple vaccinations covered if recommended by the Missouri Department of Health and Senior Services or by the Centers for Disease Control and Prevention.

(I) Standard or preservative-free injectable influenza vaccine is a medically-necessary preventive service for members when influenza immunization is recommended by the member's doctor.

(II) Intradermal influenza vaccine is a medically-necessary preventive service for members eighteen (18) to sixty-four (64) years of age when influenza immunization is recommended by the member's doctor.

(III) Intranasally administered influenza vaccine is a medically-necessary alternative to injectable influenza vaccine for immunocompetent healthy persons two (2) to forty-nine (49) years of age when influenza immunization is recommended by the member's doctor;

33. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement not covered unless due to normal wear and tear, if there is a change in medical condition, or if growth-related;

34. Pulmonary rehabilitation. Up to thirty-six (36) visits within a twelve- (12-) week period per incident. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and postoperative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) and/or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or less than twenty milliliters per kilogram per minute (20 ml/kg/min), or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

35. Skilled nursing facility. Benefits are limited to one hundred twenty (120) days per calendar year;

36. Stimulators (for bone growth). Implantable bone growth stimulators covered as an outpatient surgery, nonimplantable bone growth stimulator covered under durable medical equipment.

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)). Medically-necessary DME to accelerate healing of fresh fractures, fusions, or delayed unions.

B. Electrical stimulation. Direct current electrical bone-growth stimulator medically necessary for delayed unions of fractures or failed arthrodesis, non-unions, failed fusions, and congenital pseudarthrosis and members who are at high risk for spinal fusion failure;

37. Transplants. When neither experimental nor investigational and medically necessary: bone marrow, kidney, liver, heart, lung, pancreas, intestinal, or any combination are covered under the transplant benefits. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements. Travel, if approved, is limited to ten thousand dollars ($10,000) maximum per transplant.

A. Network. Includes travel and lodging allowance for recipient and his/her immediate family travel companion (younger than nineteen (19), both parents) if transplant facility is more than one hundred (100) miles from residence.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Transplant benefits at a non-network facility. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals not covered. Non-network facility charges and payments for transplants are limited to the following maximum only:

(I) Allogenic bone marrow—one hundred forty three thousand dollars ($143,000);

(II) Autologous bone marrow—one hundred twenty-one thousand dollars ($121,000);

(III) Heart—one hundred twenty-eight thousand dollars ($128,000);

(IV) Heart and lung—one hundred thirty-three thousand dollars ($133,000);

(V) Lung—one hundred fifty-one thousand dollars ($151,000);

(VI) Kidney—Fifty-four thousand dollars ($54,000);

(VII) Kidney and pancreas—ninety-seven thousand dollars ($97,000); and

(VIII) Liver—one hundred fifty-three thousand dollars ($153,000);

38. Urgent care. Services to prevent rapid and/or serious deterioration in a member's health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate for injuries too severe to be seen in a primary care physician's office but not severe enough to require treatment in a hospital emergency department; and

39. Vision. Routine exam (including refractions). One (1) per covered person per calendar year.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.060 PPO 300 Plan, PPO 600 Plan, and HDHP Limitations **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2756–2759). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.070 Coordination of Benefits **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2760–2761). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.075 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2761–2764). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received one (1) comment on the proposed amendment.

COMMENT: MCHCP staff commented that the effective date of plan selection changes requested through appeal to the board should be reconsidered.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the specific effective date of plan selection changes of February 1 has been removed from the rule because the effective date may vary depending upon the specific plan change requested.

22 CSR 10-2.075 Review and Appeals Procedure

(6) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines.

(C) Any member wishing to change his/her plan selection made during the annual open enrollment period must request to do so in writing to the board of trustees within thirty-one (31) calendar days of the beginning of the new plan year. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.090 Pharmacy Benefit Summary **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2764–2768). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director rescinds a rule as follows:

22 CSR 10-2.092 Dental Benefit Summary **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2769–2770). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

22 CSR 10-2.092 Dental Coverage **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2770–2771). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director rescinds a rule as follows:

22 CSR 10-2.093 Vision Benefit Summary **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2772). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

22 CSR 10-2.093 Vision Coverage **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2772–2773). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

22 CSR 10-2.095 TRICARE Supplement Plan **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2776–2777). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

22 CSR 10-2.100 Fully-Insured Medical Plan Provisions **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2778). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.010 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2778–2785). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received two (2) comments on the proposed amendment.

COMMENT #1: MCHCP staff commented that a definition for "active employee" should be added to clarify the difference between current employees and retirees.
RESPONSE AND EXPLANATION OF CHANGE: Based on this comment, a definition for "active employee" was added and definitions and citations were renumbered as needed.

COMMENT #2: The Missouri State Medical Association (MSMA), commented that, under the definition of "doctor/physician," psychiatrists do not need to be listed separately, as a psychiatrist is a doctor of medicine or doctor of osteopathy. MSMA also commented that the definition of "provider" includes "therapist with a PhD or Master's Degree in Psychiatry," when there are no PhD or masters degree in psychiatry.
RESPONSE AND EXPLANATION OF CHANGE: Based on this comment, psychiatrist is removed from the definition of "doctor/physician," as a psychiatrist is already included in doctor of medicine or doctor of osteopathy, and the definition of provider is amended to include a "therapist with a PhD or Master's Degree in Psychology or Counseling."

22 CSR 10-3.010 Definitions

(2) Active employee. A benefit-eligible person employed by a public entity who meets the plan eligibility requirements.

(3) Activities of daily living. Bathing, dressing, toileting, and associated personal hygiene; transferring (being moved in and out of a bed, chair, wheelchair, tub, or shower); mobility, eating (getting nourishment into the body by any means other than intravenous), and continence (voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene).

(4) Administrative appeal. A written request submitted by or on behalf of a member involving plan-related administrative issues such as eligibility, effective dates of coverage, and plan changes.

(5) Adverse benefit determination. An adverse benefit determination means any of the following:

(A) A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit based on a determination of an individual's eligibility to participate in the plan;

(B) A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental, investigational, or not medically necessary or appropriate; or

(C) Rescission of coverage after an individual has been covered under the plan.

(6) Allowable amount. Maximum amount on which payment is based for covered health care services. This may be called eligible expense, payment allowance, or negotiated rate. If the provider charges more than the allowed amount, the member may be balance-billed (see balance billing, section (8)).

(7) Applied behavior analysis. The design, implementation, and evaluation of environmental modifications, using behavior stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of observation, measurement, and functional analysis of the relationship between environment and behavior.

(8) Balance billing. When a provider bills for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is one hundred dollars ($100) and the allowed amount is seventy dollars ($70), the provider may bill the member for the remaining thirty dollars ($30). A network provider may not balance bill.

(9) Benefits. Health care services covered by the plan.

(10) Board. The board of trustees of the Missouri Consolidated Health Care Plan (MCHCP).

(11) Cancellation of coverage. The ending of medical, dental, or vision coverage per a subscriber's voluntary request.

(12) Case management. A coordinated set of activities conducted for individual patient management of serious or complicated health conditions.

(13) Claims administrator. An organization or group responsible for the processing of claims and associated services for a health plan.

(14) Coinsurance. The member's share of the costs of a covered health care service, calculated as a percent (for example, twenty percent (20%)) of the allowed amount for the service. The member pays coinsurance plus any deductibles owed. For example, if the health insurance or plan's allowed amount for an office visit is one hundred dollars ($100) and the member has met his/her deductible, the member's coinsurance payment of twenty percent (20%) would be twenty dollars ($20). The health insurance or plan pays the rest of the allowed amount.

(15) Congenital defect. Existing or dating from birth. Acquired through development while in the uterus.

(16) Copayment. A fixed amount, for example, fifteen dollars ($15), the member pays for a covered health care service, usually when the member receives the service. The amount can vary by the type of covered health care service.

(17) Date of service. Date medical services are received.

(18) Deductible. The amount the member owes for health care services that the health plan covers before the member's health plan begins to pay. For example, if the deductible is one thousand dollars ($1,000), the member's plan will not pay anything until s/he meets his/her one thousand dollars ($1,000) deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

(19) Disease management. A program offered to members, who do not have primary Medicare coverage, to help manage certain chronic diseases.

(20) Doctor/physician. A licensed practitioner of the healing arts, as approved by the plan administrator, including:

(A) Doctor of medicine;

(B) Doctor of osteopathy;

(C) Podiatrist;

(D) Optometrist;

(E) Chiropractor;

(F) Psychologist;

(G) Doctor of dental medicine, including dental surgery;

(H) Doctor of dentistry; or

(I) Qualified practitioner of spiritual healing whose organization is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.

(21) Effective date. The date on which coverage takes effect as described in 22 CSR 10-3.020(4).

(22) Eligibility date. The first day a member is qualified to enroll for coverage as described in 22 CSR 10-3.020(2).

(23) Eligibility period. The time allowed to enroll in accordance with the rules in this chapter.

(24) Emergency medical condition. The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

(A) Placing a person's health in significant jeopardy;

(B) Serious impairment to a bodily function;

(C) Serious dysfunction of any bodily organ or part;

(D) Inadequately controlled pain; or

(E) With respect to a pregnant woman who is having contractions—

1. That there is inadequate time to effect a safe transfer to another hospital before delivery; or

2. That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

(25) Emergency services. With respect to an emergency medical condition—

(A) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department to evaluate such emergency medical condition; and

(B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required to stabilize the patient. The term "to stabilize" means to provide such medical treatment of the condition as may be necessary to ensure, within reasonable medical probability that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility.

(26) Employee. A benefit-eligible person employed by a participating public entity and present and future retirees from the participating public entity who meet the plan-eligibility requirements.

(27) Employer. The public entity that employs the eligible employee.

(28) Essential benefits. The plan covers essential benefits as required by the Patient Protection and Affordable Care Act. Essential benefits include:

(A) Ambulatory patient services—office visits, urgent care, outpatient diagnostic procedures, outpatient surgery, and outpatient hospice;

(B) Emergency services—ambulance services and emergency room services;

(C) Hospitalization—inpatient hospital benefits, inpatient surgery, transplants, and inpatient hospice;

(D) Maternity and newborn care—maternity coverage and newborn screenings;

(E) Mental health and substance abuse disorder services, including behavioral health treatment—inpatient and outpatient and mental health/chemical dependency office visits;

(F) Prescription drugs;

(G) Rehabilitative and habilitative services and devices—durable medical equipment; cardiac and pulmonary rehabilitation; outpatient physical, speech, and occupational therapy; and home health care;

(H) Laboratory services—lab and X-ray;

(I) Preventive and wellness services and chronic disease management; and

(J) Pediatric services, including oral and vision care—routine vision exam, dental care/accidental injury, immunizations, preventive services, and newborn screenings.

(29) Excluded services. Health care services that the member's health plan does not pay for or cover.

(30) Executive director. The chief executive officer of the Missouri Consolidated Health Care Plan (MCHCP), who shall have charge of the offices, records, and employees of the plan, subject to the direction of the board of trustees.

(31) Experimental/investigational/unproven. A treatment, procedure, device, or drug that meets any of the criteria listed below and that the plan administrator determines, in the exercise of its discretion, is considered experimental/investigational/unproven and is not eligible for coverage under the plan—

(A) Has not received the approval of the U.S. Food and Drug Administration for marketing the drug or device at the time it is furnished, if such approval is required by law;

(B) Is shown by reliable evidence to be the subject of ongoing Phase I clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficiency, or its efficacy as compared with the standard means of treatment or diagnosis; or

(C) Is shown by reliable evidence that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficiency as compared with the standard means of treatment or diagnosis.

(D) Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community.

(32) Formulary. A list of U.S. Food and Drug Administration approved drugs and supplies developed by the pharmacy benefit manager and covered by the plan administrator.

(33) Generic drug. A chemical equivalent of a brand-name drug with an expired patent. The color or shape may be different, but the active ingredients must be the same for both.

(34) Health savings account (HSA). A tax-advantaged savings account that may be used to pay for current or future qualified medical expenses. Enrollment in the plan's qualified High Deductible Health Plan is required for participation in an HSA.

(35) High Deductible Health Plan (HDHP). A health plan with a higher deductible than a traditional health plan that, when combined with an HSA, provides a tax-advantaged way to help save for future medical expenses.

(36) Illness. Any bodily sickness, disease, or mental/nervous disorder. For purposes of this plan, pregnancy is considered an illness.

(37) Incident. A definite and separate occurrence of a condition.

(38) Injury. A condition that results independently of an illness and all other causes and is a result of an external force or accident.

(39) Lifetime maximum. The amount payable by a medical plan during a covered member's life for specific non-essential benefits.

(40) MCHCPid. An individual MCHCP member identifier used for member verification and validation.

(41) myMCHCP. A secure MCHCP member website that allows members to review coverage selections, verify covered dependents, make coverage changes, add/change email address, and access health plan websites.

(42) Medically necessary. Treatments, procedures, services, or supplies that the plan administrator determines, in the exercise of its discretion—

(A) Are expected to be of clear clinical benefit to the patient; and

(B) Are appropriate for the care and treatment of the injury or illness in question; and

(C) Conform to standards of good medical practice as supported by applicable medical and scientific literature. A treatment, procedure, service, or supply must meet all criteria listed above to be considered medically necessary and to be eligible for coverage under the plan. In addition, the fact that a provider has prescribed, ordered, or recommended a treatment, procedure, service, or supply does not, in itself, mean that it is medically necessary as defined above. Further, the treatment, procedure, service, or supply must not be specifically excluded from coverage under this plan.

(43) Medicare-approved amount. The fee Medicare sets as reasonable for a covered medical service. This is the amount a provider is paid by the member and Medicare for a service or supply. It may be less than the actual amount charged by a health care provider.

(44) Medicare assignment. When a health care provider agrees to accept the Medicare-approved amount as payment in full for claims.

(45) Member. Any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.

(46) Network. The facilities, providers, and suppliers the health insurer or plan has contracted with to provide health care services.

(47) Non-formulary. A drug not contained on the pharmacy benefit manager's list of covered drugs.

(48) Non-network. The facilities, providers, and suppliers the health plan does not contract with to provide health care services.

(49) Out-of-pocket maximum. The most the member will pay during a plan year before the plan begins to pay one hundred percent (100%) of the allowed amount. This limit never includes the member's premium, copayments, balance-billed charges, or health care services the plan does not cover.

(50) Participant. Shall have the same meaning as the term member defined herein (see member, section (45)).

(51) Plan. The program of health care benefits established by the board of trustees of the Missouri Consolidated Health Care Plan as authorized by state law.

(52) Plan administrator. The board of trustees of the Missouri Consolidated Health Care Plan, which is the sole fiduciary of the plan. The board has all discretionary authority to interpret its provisions and to control the operation and administration of the plan and whose decisions are final and binding on all parties.

(53) Plan year. The period of January 1 through December 31.

(54) Preferred provider organization (PPO). An arrangement with providers whereby discounted rates are given to plan members. Benefits are paid at a higher level when network providers are used.

(55) Premium. The monthly amount that must be paid for health insurance.

(56) Primary care physician (PCP). An internist, family/general practitioner, or pediatrician.

(57) Prior authorization. A decision by the plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called pre-authorization, prior approval, or precertification. The plan may require prior authorization for certain services before the member receives them, except in an emergency. Prior authorization is not a promise the plan will cover the cost. The provider must contact the appropriate plan administrator to request prior authorization.

(58) Provider. A physician, hospital, medical agency, specialist, or other duly licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-3.010(20). Other providers include but are not limited to:

(A) Audiologist (AUD or PhD);

(B) Certified Addiction Counselor for Substance Abuse (CAC);

(C) Certified Nurse Midwife (CNM)—when acting within the scope of his/her license in the state in which s/he practices and performing a service which would be payable under this plan when performed by a physician;

(D) Certified Social Worker or Masters in Social Work (MSW);

(E) Chiropractor;

(F) Licensed Clinical Social Worker;

(G) Licensed Professional Counselor (LPC);

(H) Licensed Psychologist (LP);

(I) Nurse Practitioner (NP);

(J) Physician Assistant (PA);

(K) Occupational Therapist;

(L) Physical Therapist;

(M) Speech Therapist;

(N) Registered Nurse Anesthetist (CRNA);

(O) Registered Nurse Practitioner (ARNP); or

(P) Therapist with a PhD or Master's Degree in Psychology or Counseling.

(59) Prudent layperson. An individual possessing an average knowledge of health and medicine.

(60) Public entity. A state-sponsored institution of higher learning, political subdivision, or governmental entity or instrumentality that has elected to join the plan and has been accepted by the board.

(61) Qualified Medical Child Support Order (QMCSO). A child support order from a court of competent jurisdiction or state child care agency, which requires the plan to provide coverage for a dependent child or member if the plan normally provides coverage for dependent children.

(62) Retiree. A former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-3.020(2)(D) and is currently receiving a monthly retirement benefit from a public entity.

(63) Sound natural teeth. Teeth and/or tissue that is viable, functional, and free of disease. A sound natural tooth has no decay, fillings on no more than two (2) surfaces, no gum disease associated with bone loss, no history of root canal therapy, is not a dental implant, and functions normally in chewing and speech.

(64) Specialty care physician/specialist. A physician who is not a primary care physician and provides medical services to members concentrated in a specific medical area of expertise.

(65) Specialty medications. High cost drugs that treat chronic complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis.

(66) State. Missouri.

(67) Step therapy. Designed to encourage use of therapeutically-equivalent, lower-cost alternatives before using more expensive therapy. It is especially for people who take prescription drugs regularly to treat ongoing medical conditions and is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts.

(68) Subrogation. The substitution of one (1) "party" for another. Subrogation entitles the insurer to the rights and remedies that would otherwise belong to the insured (the subscriber) for a loss covered by the insurance policy. Subrogation allows the plan to stand in the place of the member and recover the money directly from the other insurer.

(69) Subscriber. The employee or member who elects coverage under the plan.

(70) Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.

(71) Usual, customary, and reasonable. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

(72) Vendor. The current applicable third-party administrators of MCHCP benefits.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director rescinds a rule as follows:

22 CSR 10-3.020 Subscriber Agreement and General Membership Provisions **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2785). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

22 CSR 10-3.020 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2785–2793). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received nine (9) comments on the proposed rule.

COMMENT #1: MCHCP staff commented that, under section (2), for clarification what the eligibility requirements are, subsection (2)(B) should be renumbered paragraph (2)(A)1. with the old subsection paragraph (2)(A)1. renumbered paragraph (2)(A)2.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, to clarify subsection (2)(B), was renumbered paragraph (2)(A)1. with the old paragraph (2)(B)1. renumbered paragraph (2)(A)2.

COMMENT #2: MCHCP staff commented that, under subpart (2)(B)1.B.(I)(e), clarification is needed that foster children are still eligible for coverage if the foster child relationship was in effect between the child and subscriber or spouse when the child aged out.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subpart (2)(A)2.B.(I)(e) that foster children are still eligible for coverage if the foster child relationship was in effect between the child and subscriber or spouse when the child was aged out.

COMMENT #3: MCHCP staff commented that, under paragraph (3)(B)1. and paragraph (3)(C)1., clarification is needed that employee should be active employee as those sections do not apply to retirees.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (3)(B)1. and paragraph (3)(C)1. that those paragraphs apply to active employees.

COMMENT #4: MCHCP staff commented that, under paragraph (3)(C)3., survivors are not included in public entity and thus should be removed from this section.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, survivors was removed from paragraph (3)(C)3. as survivors are not included in the public entity plan benefits.

COMMENT #5: MCHCP staff commented that, under paragraph (3)(C)4., clarification is needed that if a subscriber's spouse receives a court order for coverage of a dependent, the subscriber may enroll that dependent.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (3)(C)4. that if a subscriber's spouse receives a court order for coverage of a dependent, the subscriber may enroll that dependent.

COMMENT #6: MCHCP staff commented that, under paragraph (4)(A)3., clarification is needed regarding the effective dates for adoption, legal custody, and foster care.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification under paragraph (4)(A)3. was made regarding the effective dates for adoption, legal custody, and foster care.

COMMENT #7: MCHCP staff commented that, under paragraph (4)(A)6., clarification is needed when coverage is effective under a qualified medical child support order.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (4)(A)6., when coverage is effective under a qualified medical child support order.

COMMENT #8: MCHCP staff commented that, under paragraph (5)(A)3., clarification is needed for acceptable proof of eligibility for legal custody.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (5)(A)3. regarding acceptable proof of legal custody.

COMMENT #9: MCHCP staff commented that, under paragraph (9)(A)8., clarification is needed that vision is a benefit that is eligible to continue for an employee on military leave.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (9)(A)8. that vision was included as a benefit that is eligible to continue for an employee on military leave.

22 CSR 10-3.020 General Membership Provisions

(2) Eligibility Requirements.

(A) Employee and Dependent Eligibility Requirements. Health plans contracted with MCHCP must be made available to all eligible employees, their dependents, and retirees of the public entity. An eligible employee is one who is actively employed and meets the minimum number of hours worked per year as established by his/her employer. If the public entity allows elected/appointed officials to participate in medical coverage, the definition of an employee includes elected/appointed officials where applicable. The entity will determine the eligibility requirements of waiting periods, required number of working hours, pay status, and contribution levels.

1. An employee cannot be covered as an employee and as a dependent.

2. An eligible employee may enroll eligible dependents as long as the eligible employee is also enrolled. Eligible dependents include:

A. Spouse.

(I) A public entity retiree may enroll as a spouse under an employee's coverage or elect coverage as a retiree.

(II) If one (1) spouse is a state employee with MCHCP benefits and the other is a public entity employee with MCHCP benefits, each spouse may enroll under his or her employer's plan or together under one (1) employer's plan. The spouses cannot have coverage in both places; and

B. Children.

(I) Children may be covered through the end of the month in which they turn twenty-six (26), if they meet one (1) of the following criteria:

(a) Natural child of subscriber or spouse;

(b) Legally-adopted child of subscriber or spouse;

(c) Child legally placed for adoption of subscriber or spouse;

(d) Stepchild of subscriber or spouse;

(e) Foster child of subscriber or spouse. Such child will continue to be considered a dependent child after the foster child relationship ends by operation of law when the child ages out if the foster child relationship between the subscriber or spouse and the child was in effect the day before the child ages out;

(f) Grandchild for whom the covered subscriber or covered spouse has legal guardianship or legal custody;

(g) A child for whom the subscriber or spouse is the court-ordered legal guardian under a guardianship of a minor. Such child will continue to be considered a dependent child after the guardianship ends by operation of law when the child becomes eighteen (18) years of age if the guardianship of a minor relationship between the subscriber or spouse and the child was in effect the day before the child became eighteen (18) years of age;

(h) Newborn of a subscriber or a covered dependent;

(i) Child for whom the subscriber or covered spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); or

(j) Child who is twenty-six (26) or older and is permanently disabled in accordance with subsection (5)(C), only if such child was an MCHCP member the day before the child turned twenty-six (26).

(II) A child may only be covered by one (1) parent if his/her parents are married and are both covered under an MCHCP medical plan.

(III) A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. MCHCP will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim first. The second claim for the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for the longest period of time.

(B) Changes in Dependent Status. If a covered dependent loses his/her eligibility, the public entity and subscriber must notify MCHCP within thirty-one (31) days to terminate his/her coverage effective the end of the month eligibility ceases.

(C) Retiree and Dependent Eligibility Requirements. A retiree and his/her dependents will remain eligible as long as the entity remains with MCHCP.

1. To enroll or continue coverage at retirement, the employee and his/her dependents must provide all of the following:

A. Submit a completed enrollment form within thirty-one (31) days of retirement date. Coverage is effective on retirement date.

(I) Submit proof of prior coverage and proof of eligibility for dependents if s/he and his/her dependents choose to enroll in an MCHCP plan at retirement and have had other insurance coverage for six (6) months immediately prior to his/her retirement.

2. Employees may continue coverage on their eligible dependents into retirement.

3. A retiree may only add dependents to his/her coverage when—

A. A life event occurs; or

B. A dependent's employer-sponsored coverage ends due to one (1) of the following, provided that the dependent's employer-sponsored coverage was in place for twelve (12) months immediately prior to the loss, and MCHCP coverage is requested within sixty (60) days of the termination date of the previous coverage:

(I) Termination of employment;

(II) Retirement; or

(III) Termination of group coverage by the employer.

4. A retiree and/or his/her dependents may continue dental and/or vision coverage into retirement without medical coverage.

(3) Enrollment Procedures.

(B) Open Enrollment.

1. An active employee may elect coverage and/or change coverage levels during the annual open enrollment period if one (1) of the following occurred:

A. Waived his/her right to insurance when first eligible;

B. Did not enroll eligible dependents when first eligible; or

C. Dropped his/her or dependent coverage during the year.

2. A retiree may change from one (1) medical plan to another during open enrollment but cannot add a dependent. If a retiree is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in a plan during open enrollment.

(C) Special Enrollment Periods.

1. An active employee may apply for coverage for himself/herself or for his/her dependents if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of adopted children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. An employee and his/her dependents may enroll within sixty (60) days if s/he involuntarily loses employer-sponsored coverage under one (1) of the following circumstances, and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. A retiree may apply for dependent coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth,

adoption, and placement of adopted children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. A retiree may enroll his/her dependent within sixty (60) days if the dependent involuntarily loses employer-sponsored coverage under one (1) of the following circumstances. Dependent employer-sponsored coverage must be in place for twelve (12) months immediately prior to the loss, and MCHCP coverage must be requested within sixty (60) days of the termination date of the previous coverage:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. MO HealthNet or Medicaid status loss. If an employee who is not retired or his/her dependent loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss.

4. Qualified Medical Child Support Order. If a subscriber or a subscriber's spouse receives a court order stating s/he is responsible for coverage of dependent, the subscriber may enroll the dependent(s) in an MCHCP plan within sixty (60) days of the court order.

5. If an active employee has elected coverage as a dependent of another MCHCP subscriber as allowed by these rules, and the subscriber dies before coverage as a dependent goes into effect, the active employee may elect coverage as a subscriber within thirty-one (31) days of the date of death.

(4) Effective Date Provision. In no circumstances can the effective date be before the eligibility date. The effective date of coverage shall be determined, subject to the effective date provisions as follows:

(A) Employee and Dependent Effective Dates.

1. A new employee and his/her eligible dependent(s), or an employee rehired after his/her coverage terminates, and his/her eligible dependent(s) are eligible to participate in the plan on the first day of the month following the employee's eligibility date as determined by the employer.

2. Except at initial employment, an employee and his/her eligible dependents' effective date of coverage is the first of the month coinciding with, or after the eligibility date and applicable waiting period. The effective date of coverage cannot be prior to the date of receipt of the enrollment by MCHCP, except for newborns.

3. The effective date of coverage for a life event shall be as follows:

A. If enrollment by an employee is made before a wedding date, spouse's coverage becomes effective on the wedding date. The monthly premium is not prorated;

B. If enrollment by an employee is made within thirty-one (31) days of a wedding date, spouse's coverage becomes effective the first of the month coinciding with or after receipt of the enrollment form and proof of eligibility;

C. If enrollment by a subscriber is made for a newborn of a member, the effective date for the newborn is the birth date. If enrollment is made by an employee due to the birth of a newborn of the employee, the effective date for the employee and newborn is the first of the month coinciding with or after enrollment is received;

D. If enrollment by an employee is made prior to the eligibility date for an adoption or placement of children, coverage becomes effective on the eligibility date;

E. If enrollment by an employee is made within thirty-one (31) days after the eligibility date, for an adoption, or placement of children, coverage becomes effective on the first day of the calendar month coinciding with or after the date the enrollment is received;

F. Legal guardianship and legal custody. If enrollment by an employee is made due to legal guardianship or legal custody of a dependent within thirty-one (31) days of guardianship or custody effective date, the effective date for coverage is the first day of the calendar month coinciding with or after the date the enrollment is received; or

G. Foster care. If enrollment by an employee is made due to placement of a foster child in the employee's care within thirty-one (31) days of placement, the effective date for coverage is the first day of the calendar month coinciding with or after the date the enrollment is received.

4. An employee and his/her eligible dependent(s) who elect coverage and/or change coverage levels during open enrollment shall have an effective date of January 1 of the following year.

5. When a dependent of a subscriber first becomes eligible, coverage will become effective on the eligibility date or the first day of the month coinciding with or after the eligibility date if enrollment is made within thirty-one (31) days of the eligibility date.

6. Coverage is effective for a dependent child the first of the month coinciding with or after the Qualified Medical Child Support Order is received by the plan or date specified by the court.

(5) Proof of Eligibility.

(A) A public entity is required to obtain and keep on file proof of eligibility for dependents enrolled in a MCHCP medical, dental, and/or vision plan. Proof of eligibility documentation is required for all dependents.

1. Notification of the proof of eligibility policy will occur during the September 2012 public entity payroll representatives' informational meetings. Initial time frame for a public entity to obtain proof of eligibility documentation will occur September 1, 2012, through November 29, 2012.

2. Proof of eligibility must be obtained within thirty-one (31) days for a newly enrolled dependent and within ninety (90) days from date of birth for a newborn.

3. Coverage is provided for a newborn of a member from the moment of birth. The public entity or member must notify the plan of the birth verbally or in writing within thirty-one (31) days of the birth date. The plan will notify the public entity and member of the steps to continue coverage. The member is allowed an additional ten (10) days from the date of the plan notice to return the enrollment form. Coverage will not continue unless the enrollment form is received within thirty-one (31) days of the birth date or ten (10) days from the date of the notice, whichever is later.

4. MCHCP reserves the right to request proof of eligibility be provided at any time. If such proof is not received or is unacceptable as determined by MCHCP, coverage for the applicable dependent will be terminated or will not take effect.

5. Documentation is also required when a subscriber attempts to terminate a dependent's coverage in the case of divorce or death.

6. Acceptable forms of proof of eligibility are included in the following chart:

Circumstance	Documentation
Birth of dependent(s)	Government-issued birth certificate or other government-issued or legally-certified proof of eligibility listing subscriber as parent and newborn's full name and birth date
Addition of step-child(ren)	Marriage license to biological or legal parent/guardian of child(ren); and government-issued birth certificate or other government-issued or legally-certified proof of eligibility for child(ren) that names the subscriber's spouse as a parent or guardian and child's full name and birth date
Addition of foster child(ren)	Placement papers in subscriber's care
Adoption of dependent(s)	Adoption papers; Placement papers; or Filed petition for adoption; and Lists subscriber as adoptive parent
Legal guardianship or legal custody of dependent(s)	Court-documented guardianship or custody papers listing member as guardian or custodian (Power of Attorney is not acceptable)
Newborn of covered dependent	Government-issued birth certificate or legally-certified proof of eligibility for newborn listing covered dependent as parent with newborn's full name and birth date
Marriage	Marriage license or certificate recognized by Missouri law
Divorce	Final divorce decree; or Notarized letter from spouse stating s/he is agreeable to termination of coverage pending divorce or legal separation
Death	Death certificate
Loss of MO HealthNet or Medicaid	Letter from MO HealthNet or Medicaid stating who is covered and the date coverage terminates
MO HealthNet Premium Assistance	Letter from MO HealthNet or Medicaid stating member is eligible for the premium assistance program
Qualified Medical Child Support Order	Qualified Medical Child Support Order
Prior Group Coverage	Letter from previous insurance carrier or former employer stating date coverage terminated, reason for coverage termination, and list of dependents covered

7. Annually, MCHCP will require a signed attestation form verifying receipt of proof of eligibility from the public entity with enrolled dependents. A blank attestation form will be delivered to the public entity prior to open enrollment. Instructions to complete the form, filing requirements, and deadlines will accompany the attestation form.

(B) The employee is required to notify MCHCP on the appropriate form of the dependent's name, date of birth, eligibility date, and Social Security number.

(C) Permanently disabled children will continue to be eligible beyond age twenty-six (26) during the continuance of a permanent disability, provided the following documentation is submitted to the public entity prior to the dependent's twenty-sixth birthday:

1. The Supplemental Security Income (SSI) Notice of Award from the Social Security Administration (SSA) verifying the dependent is entitled to and receiving disability benefits as of a specific date;

2. A letter from the dependent's physician describing the disability and verifying that the disability pre-dates the SSA determination; and

3. A current benefit verification letter from the SSA confirming the dependent is still considered disabled by SSA.

(D) Members who are eligible for Medicare benefits under Part A, B, or D must notify MCHCP of their eligibility and provide a copy of the member's Medicare card within thirty-one (31) days of the Medicare eligibility date. Claims will not be processed until the required information is provided.

(9) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) Eligibility. In accordance with COBRA, eligible employees and their dependents may temporarily continue their coverage when coverage under the plan would otherwise end. Coverage is identical to the coverage provided under MCHCP to similarly-situated

employees and family members. If members cancel COBRA coverage, they cannot enroll at a later date.

1. Employees voluntarily or involuntarily terminating employment (for reasons other than gross misconduct) or receiving a reduction in the number of hours of employment may continue coverage for themselves and their covered dependent(s) for eighteen (18) months at their own expense.

2. If a subscriber marries, has a child, or adopts a child while on COBRA coverage, eligible dependents can be added to the subscriber's plan upon notification to MCHCP. The subscriber may also add eligible dependents during open enrollment.

3. Dependents may continue coverage for up to thirty-six (36) months at their own expense if the covered employee becomes eligible for Medicare.

4. A surviving spouse and dependents, not normally eligible for continued coverage, may elect coverage for up to thirty-six (36) months at their own expense.

5. A divorced spouse and dependents may continue coverage at their own expense for up to thirty-six (36) months.

6. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) expense.

7. If the Social Security Administration determines a COBRA member is disabled within the first sixty (60) days of coverage, the member may continue coverage for up to twenty-nine (29) months.

8. An employee who is on military leave is eligible for continued coverage for medical, vision, and dental care for the lesser of: a) twenty-four (24) months beginning on the date the leave begins; or b) the day after the date the employee fails to apply for or return to their position of employment following leave.

9. If the eligible member has Medicare prior to becoming eligible for COBRA coverage, the member is entitled to coverage under both.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.030 Public Entity Membership Agreement and Participation Period **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2794–2797). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.045 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2798–2799). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received one (1) comment on the proposed amendment.

COMMENT: MCHCP staff commented that it is not clear that cardiac rehabilitation and pulmonary rehabilitation are both eligible for thirty-six (36) visits within a twelve- (12-) week period.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, this rule was amended to clarify that cardiac rehabilitation and pulmonary rehabilitation are both eligible for thirty-six (36) visits within a twelve- (12-) week period.

22 CSR 10-3.045 Plan Utilization Review Policy

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) Prior Authorization of Services—The claims administrator must authorize some services in advance. Without prior authorization, any claim that requires prior authorization will not be covered. Members who have another primary carrier, including Medicare, are not subject to this provision. Prior authorization does not verify eligibility or payment. Prior authorizations based on a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition will not be covered.

1. The following medical services are subject to prior authorization:

A. Ambulance services for non-emergent use whether air or ground;

B. Anesthesia and hospital charges for dental care for children younger than five (5), the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;

C. Applied behavior analysis for autism;

D. Auditory brainstem implant (ABI);

E. Bariatric procedures;

F. Cardiac rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

G. Chiropractic services after twenty-six (26) visits annually;

H. Cochlear implant device;

I. Chelation therapy;

J. Dental care to reduce trauma and restorative services when the result of accidental injury;

K. Durable medical equipment (DME) over one thousand five hundred dollars ($1,500) or DME rentals over five hundred dollars ($500) per month;

L. Genetic testing or counseling;

M. Home health care and palliative services;

N. Hospice care;

O. Hospital inpatient services except for observation stays;

P. Maternity coverage for maternity hospital stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery;

Q. Nutritional counseling after three (3) sessions annually;

R. Orthotics over one thousand dollars ($1,000);

S. Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per incident;

T. Procedures with codes ending in "T";

U. Prostheses over one thousand dollars ($1,000);

V. Pulmonary rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

W. Skilled nursing facility;

X. Surgery (outpatient)—The following outpatient surgical procedures: cornea transplant, potential cosmetic surgery, sleep apnea surgery, implantable stimulators, stimulators for bone growth, surgeries with procedure codes ending in "T" (temporary codes used for data collection, experimental, investigational, or unproven surgeries), spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams); and

Y. Transplants including requests related to covered travel and lodging.

2. The following pharmacy services are subject to prior authorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications;

C. Medications that may be prescribed for several conditions, including some for which treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. The cost of the medication exceeds nine thousand nine hundred ninety-nine dollars and ninety-nine cents ($9,999.99) at retail pharmacy, one thousand four hundred ninety-nine dollars and ninety-nine cents ($1,499.99) at mail order, and one hundred forty-nine dollars and ninety-nine cents ($149.99) for compound medications.

3. Prior authorization time frames.

A. A benefit determination for non-urgent prior authorization requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen- (15-) calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least forty-five (45) calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent prior authorization requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.053 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2799–2802). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received two (2) comments on the proposed amendment.

COMMENT #1: MCHCP staff commented that the family out-of-pocket maximum is the combination of family member applicable charges, not the combination of family member out-of-pocket maximums.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the rule now correctly states that the family out-of-pocket maximum is the combination of family member applicable charges.

COMMENT #2: MCHCP staff commented that the benefit coverage for in-hospital days that overlap current and upcoming plan years is unclear.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the rule clarifies the benefit coverage for in-hospital days that overlap current and upcoming plan years.

22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges

(4) Out-of-pocket maximum—the maximum amount payable by the member before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(B) The family out-of-pocket maximum is an aggregate of applicable charges received by all covered members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

(7) For a member who is inpatient on the last calendar day of a plan year and remains inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.054 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2803–2805). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received two (2) comments on the proposed amendment.

COMMENT #1: MCHCP staff commented that the family out-of-pocket maximum is the combination of family member applicable

charges, not the combination of family member out-of-pocket maximums.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the rule now correctly states that the family out-of-pocket maximum is the combination of family member applicable charges.

COMMENT #2: MCHCP staff commented that the benefit coverage for in-hospital days that overlap current and upcoming plan years is unclear.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the rule clarifies the benefit coverage for in-hospital days that overlap current and upcoming plan years.

22 CSR 10-3.054 PPO 2000 Plan Benefit Provisions and Covered Charges

(4) Out-of-pocket maximum—the maximum amount payable by the member before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(B) The family out-of-pocket maximum is an aggregate of applicable charges received by all covered members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

(7) For a member who is inpatient on the last calendar day of a plan year and remains inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.055 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2806–2808). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received one (1) comment on the proposed amendment.

COMMENT: MCHCP staff commented that the benefit coverage for in-hospital days that overlap current and upcoming plan years is unclear.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the rule clarifies the benefit coverage for in-hospital days that overlap current and upcoming plan years.

22 CSR 10-3.055 High Deductible Health Plan Benefit Provisions and Covered Charges

(8) For a member who is inpatient on the last calendar day of a plan year and remains inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.056 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2809–2811). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received two (2) comments on the proposed amendment.

COMMENT #1: MCHCP staff commented that the family out-of-pocket maximum is the combination of family member applicable charges, not the combination of family member out-of-pocket maximums.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the rule now correctly states that the family out-of-pocket maximum is the combination of family member applicable charges.

COMMENT #2: MCHCP staff commented that the benefit coverage for in-hospital days that overlap current and upcoming plan years is unclear.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the rule clarifies the benefit coverage for in-hospital days that overlap current and upcoming plan years.

22 CSR 10-3.056 PPO 600 Plan Benefit Provisions and Covered Charges

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(B) The family out-of-pocket maximum is an aggregate of applicable charges received by all covered members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

(6) For a member who is inpatient on the last calendar day of a plan year and remains inpatient into the next plan year, the prior plan year's applicable deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director rescinds a rule as follows:

22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2812). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

22 CSR 10-3.057 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2812–2818). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received one (1) comment on the proposed rule.

COMMENT: MCHCP staff commented that clarification is needed that preventive colorectal screening will be covered in compliance with federal law.
RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, this rule was amended to clarify that preventive colorectal screening will be covered in compliance with federal law.

22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges

(2) Covered Charges Applicable to the PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP.

(F) Plan benefits for the PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP are as follows:

1. Allergy testing and immunotherapy. Allergy testing and allergy immunotherapy is covered for members with clinically-significant allergic symptoms. No coverage for non-physician allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning;

2. Ambulance service. Ambulance transport services involve the use of specially-designed and equipped vehicles to transport ill or injured individuals. Ambulance transportation by ground to the nearest appropriate facility is covered when medically necessary and other means of transportation would be contraindicated. This can include emergent and non-emergent, yet medically necessary situations. Ambulance transportation by air to the nearest appropriate facility is covered when medically necessary and only if the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate. Medical necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. Use of air ambulance or medical helicopter service from any country returning to the U.S. is excluded;

3. Applied behavior analysis for autism. For children younger than age nineteen (19), the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of observation, measurement, and functional analysis of the relationship between environment and behavior are covered with a forty thousand dollar ($40,000) annual limit. The annual limit may be exceeded, upon prior authorization by the medical plan, if services beyond the annual limit are medically necessary;

4. Bariatric surgery. Open or laparoscopic Roux-en-Y gastric bypass (RYGB), open or laparoscopic sleeve gastrectomy (SG), open or laparoscopic biliopancreatic diversion (BPD) with or without duodenal switch (DS), or laparoscopic adjustable silicone gastric banding (LASGB) are covered when specific health criteria are met;

5. Birth control devices and injections. Birth control is any method used to prevent pregnancy. Food and Drug Administration (FDA)-approved birth control devices and injections are covered when administered in a physician's office;

6. Cancer trials. Coverage for routine patient care costs incurred as the result of a Phase II, III, or IV clinical trial that is approved by an appropriate entity and is undertaken for the purposes of the prevention, early detection, or treatment of cancer. Coverage includes routine patient care costs incurred for drugs and devices that have been approved for sale by the FDA, regardless of whether they have been approved by the FDA for use in treating the patient's condition. Coverage includes reasonable and medically-necessary services needed to administer the drug or use the device under evaluation in the clinical trial;

7. Cardiac rehabilitation. Coverage for an electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) as medically necessary when it is individually prescribed by a physician and a formal exercise stress test is completed following the event and prior to the initiation of the program. Up to thirty-six (36) visits are covered within a twelve- (12-) week period per incident. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

8. Chelation therapy. Chelation therapy agents covered for FDA-approved indication(s) and associated condition(s). Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit are explicitly excluded under MCHCP's benefit plan. Therefore, treatment of metal toxicity that occurs as a result of occupational exposure is not covered;

9. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered. Up to twenty-six (26) visits covered annually. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

10. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation is covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device.

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

11. Dental care/accidental injury. Treatment to reduce trauma and restorative services only when the result of accidental injury to sound, natural teeth and tissue that are viable, functional, and free of

disease. Oral surgery is covered when medically necessary as a direct result of injury, tumors, or cysts. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5), the severely disabled, or a person with a medical or behavioral condition that requires hospitalization. General anesthesia is covered when dental care is provided in a participating or non-participating hospital or surgical center;

12. Durable medical equipment (DME)/medically-necessary disposable supplies. DME is covered when the equipment is ordered by a physician to treat an injury or sickness (illness). DME includes, but is not limited to, insulin pumps, oxygen, augmentative communication devices, and manual and powered mobility devices. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, colostomy and ureterostomy bags and prescription compression stockings, are covered. Prescription compression stockings are limited to two (2) pairs or four (4) individual stockings per plan year. Non-reusable disposable supplies, including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinence pads, irrigating kits, pressure leotards, surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are not covered. Repair and replacement of DME is covered when—

A. Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

B. Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

C. The physician provides documentation that the condition of the member changes or if growth-related;

13. Emergency room services. An emergency medical condition is defined as the manifestation of acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child. If admitted to hospital, may be required to transfer to network facility for maximum benefit;

14. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement immediately following cataract surgery;

15. Foot care (trimming of nails, corns, or calluses). Foot care services are covered when associated with systemic conditions that are significant enough to result in severe circulatory insufficiency and/or areas of desensitization in the lower extremities and service is provided by a qualified health provider. Foot care is considered routine in nature and not medically necessary in the absence of systemic disease that has resulted in severe circulatory insufficiency and/or areas of desensitization in the lower extremities;

16. Genetic counseling. The National Society of Genetic Counselors defines genetic counseling as: "The process of helping people understand and adapt to the medical, psychological, and familial implications of genetic contributions to disease." Pre-test and post-test genetic counseling with a physician or a licensed or certified genetic counselor covered as medically necessary for an individual recommended for covered heritable genetic testing;

17. Genetic testing. No coverage for testing based on family history alone. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

A. The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

B. The result of the test will directly impact the treatment being delivered to the member;

C. The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

D. After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain;

18. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

19. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars ($200), and the lifetime maximum is three thousand two hundred dollars ($3,200);

20. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

A. Conventional: one thousand dollars ($1,000).

B. Programmable: two thousand dollars ($2,000).

C. Digital: two thousand five hundred dollars ($2,500).

D. Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars ($3,500);

21. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by physician;

22. Home health care. Skilled home health care is covered for members who are homebound because of illness or injury (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent, or of short duration, or to receive medical care); services must be performed by a registered nurse or licensed practical (vocational) nurse, licensed therapist, or a registered dietitian;

23. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care which is directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week;

24. Hospital (includes inpatient, outpatient, and surgical centers). The following benefits are covered:

A. Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

B. Intensive care unit room and board;

C. Surgery, therapies, and ancillary services—

(I) Cornea transplant-travel and lodging are not covered for cornea transplant;

(II) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(III) Sterilization for the purpose of birth control is covered;

(IV) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(V) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19); and

(VI) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

D. Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(I) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(II) The member's mental health disorder must be treatable in an inpatient facility;

(III) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association *Diagnostic and Statistical Manual* (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region; and

(IV) The attending physician must be a psychiatrist. If the admitting physician is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board eligible or board certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending physician must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

E. Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an outpatient setting. The treatment program is generally a minimum of twenty (20) hours of scheduled programming extended over a minimum of five (5) days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment;

F. Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and

G. Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(I) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(II) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(III) A state-licensed psychologist;

(IV) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(V) Licensed professional counselor;

25. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition;

26. Maternity coverage. Prenatal and postnatal care is covered. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after normal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post-discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home. During a hospital admission for delivery, only the mother's claims will be subject to a deductible and coinsurance when the mother is covered under the plan. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or transfer to another facility;

27. Nutritional counseling. Individualized nutritional evaluation and counseling as for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian), up to three (3) sessions annually with a registered dietitian, with physician order. The maximum may be exceeded for an additional three (3) sessions, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary. Does not cover individualized nutritional evaluation and counseling for the management of conditions where appropriate diet and eating habits have not been proven to be essential to the overall treatment program because they are not considered to be medically necessary. Conditions for which nutritional evaluation and counseling are not considered to be medically necessary include, but are not limited to, the following:

A. Attention-deficit/hyperactivity disorder (ADHD);

B. Chronic fatigue syndrome (CFS);

C. Idiopathic environmental intolerance (IEI); or

D. Asthma;

28. Nutritional therapy. Nutritional therapy is covered when it is the sole source of nutrition or a significant percentage of the daily caloric intake; is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder; is prescribed by a physician; is necessary to sustain life or health; and requires ongoing evaluation and management by a licensed healthcare provider;

29. Office visit. Member encounter with a health care or mental health care/chemical dependency provider in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan being provided, including non-specialty infusions and injections. Specialty injections NEUPOGEN® (Filgrastim) and Neulasta® (Pegfilgrastim) are covered under the medical plan when the treating physician deems it medically necessary to be administered in the physician's office rather than as a self-injectable;

30. Orthotics. Therapeutic shoes, inserts, and/or modifications to therapeutic shoes; thoracic-lumbar-sacral orthosis, lumbar orthosis, or lumbar-sacral orthosis; helmets—covered when cranial protection is required due to a documented medical condition that makes the recipient susceptible to injury during activities of daily living; and cranial orthosis for plagiocephaly, cervical orthosis, hip orthosis, knee orthosis, and ankle-foot/knee-ankle-foot orthoses (AFO) are covered;

31. Physical, speech, and occupational therapy and rehabilitation services (outpatient). Up to sixty (60) combined visits allowed per incident if showing significant improvement. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

32. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Annual physical exams (well man, woman, and child) and routine lab and X-ray services ordered as part of the annual exam. One (1) exam per calendar year is covered. For benefits to be covered as preventive, including X-rays and lab services, they must be

coded by your physician as routine, without indication of an injury or illness.

F. Cancer screenings—

(I) Mammograms—one (1) exam per year, no age limit;

(II) Pap smears—one (1) per year, no age limit;

(III) Prostate—one (1) per year, no age limit; and

(IV) Colorectal screening—One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema per year covered as preventive even if the primary diagnosis is not a preventive code provided a preventive code is included in connection with the screening. Virtual colonoscopy covered as diagnostic only. Additional colorectal screenings covered as diagnostic unless otherwise specified.

G. Flu vaccination (influenza). The seasonal flu vaccine is covered under the preventive care benefit. When shot is obtained out-of-network, member must submit a receipt and a Non-Network Flu Shot Reimbursement form to medical plan to receive up to twenty-five dollars ($25). Multiple vaccinations covered if recommended by the Missouri Department of Health and Senior Services or by the Centers for Disease Control and Prevention.

(I) Standard or preservative-free injectable influenza vaccine is a medically-necessary preventive service for members when influenza immunization is recommended by the member's doctor.

(II) Intradermal influenza vaccine is a medically-necessary preventive service for members eighteen (18) to sixty-four (64) years of age when influenza immunization is recommended by the member's doctor.

(III) Intranasally administered influenza vaccine is a medically-necessary alternative to injectable influenza vaccine for immunocompetent healthy persons two (2) to forty-nine (49) years of age when influenza immunization is recommended by the member's doctor;

33. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement not covered unless due to normal wear and tear, if there is a change in medical condition, or if growth-related;

34. Pulmonary rehabilitation. Up to thirty-six (36) visits within a twelve- (12-) week period per incident. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and postoperative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) and/or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or less than twenty milliliters per kilogram per minute (20 ml/kg/min), or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

35. Skilled nursing facility. Benefits are limited to one hundred twenty (120) days per calendar year;

36. Stimulators (for bone growth). Implantable bone growth stimulators covered as an outpatient surgery, nonimplantable bone growth stimulator covered under durable medical equipment.

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)). Medically-necessary DME to accelerate healing of fresh fractures, fusions, or delayed unions.

B. Electrical stimulation. Direct current electrical bone-growth stimulator medically necessary for delayed unions of fractures or failed arthrodesis, non-unions, failed fusions, and congenital pseudarthrosis and members who are at high risk for spinal fusion failure;

37. Transplants. When neither experimental nor investigational and medically necessary: bone marrow, kidney, liver, heart, lung, pancreas, intestinal, or any combination are covered under the transplant benefits. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements. Travel, if approved, is limited to ten thousand dollars ($10,000) maximum per transplant.

A. Network. Includes travel and lodging allowance for recipient and his/her immediate family travel companion (younger than nineteen (19), both parents) if transplant facility is more than one hundred (100) miles from residence.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Transplant benefits at a non-network facility. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals not covered. Non-network facility charges and payments for transplants are limited to the following maximum only:

(I) Allogenic bone marrow—one hundred forty three thousand dollars ($143,000);

(II) Autologous bone marrow—one hundred twenty-one thousand dollars ($121,000);

(III) Heart—one hundred twenty-eight thousand dollars ($128,000);

(IV) Heart and lung—one hundred thirty-three thousand dollars ($133,000);

(V) Lung—one hundred fifty-one thousand dollars ($151,000);

(VI) Kidney—Fifty-four thousand dollars ($54,000);

(VII) Kidney and pancreas—ninety-seven thousand dollars ($97,000); and

(VIII) Liver—one hundred fifty-three thousand dollars ($153,000);

38. Urgent care. Services to prevent rapid and/or serious deterioration in a member's health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate for injuries too severe to be seen in a primary care physician's office but not severe enough to require treatment in a hospital emergency department; and

39. Vision. Routine exam (including refractions). One (1) per covered person per calendar year.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.060 PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP Limitations **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2819–2822). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.070 Coordination of Benefits **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2823–2824). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.075 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2824–2827). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received one (1) comment on the proposed amendment.

COMMENT: MCHCP staff commented that the effective date of plan selection changes requested through appeal to the board should be reconsidered.

RESPONSE AND EXPLANATION OF CHANGE: Based upon this comment, the specific effective date of plan selection changes of February 1 has been removed from the rule because the effective date may vary depending upon the specific plan change requested.

22 CSR 10-3.075 Review and Appeals Procedure

(6) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines.

(C) Any member wishing to change his/her plan selection made during the annual open enrollment period must request to do so in writing to the board of trustees within thirty-one (31) calendar days of the beginning of the new plan year. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.090 Pharmacy Benefit Summary **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2827–2831). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director rescinds a rule as follows:

22 CSR 10-3.092 Dental Benefit Summary **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2832). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

22 CSR 10-3.092 Dental Coverage **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2832–2834). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director rescinds a rule as follows:

22 CSR 10-3.093 Vision Benefit Summary **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2835). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

22 CSR 10-3.093 Vision Coverage **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2835–2836). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

22 CSR 10-3.100 Fully-Insured Medical Plan Provisions **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 1, 2011 (36 MoReg 2837). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

STATUTORY LIST OF CONTRACTORS BARRED FROM PUBLIC WORKS PROJECTS

The following is a list of contractor(s) who have been prosecuted and convicted of violating the Missouri Prevailing Wage Law, and whose Notice of Conviction has been filed with the Secretary of State pursuant to Section 290.330, RSMo. In addition, this list includes contractor(s) that have agreed to placement on the list maintained by the Secretary of State pursuant to Section 290.330 as a part of the resolution of criminal charges of violating the Missouri Prevailing Wage Law. Under this statute, no public body shall award a contract for public works to any contractor or subcontractor, or simulation thereof, during the time that such contractor or subcontractor's name appears on this state debarment list maintained by the Secretary of State.

Contractors Convicted of Violations of the Missouri Prevailing Wage Law

Name of Contractor	Name of Officers	Address	Date of Conviction	Debarment Period
Rycoblake Corp. Case No. 0916-CR03145 (Jackson County Cir. Ct.)		4212 SE Saddlebrook Cir Lee's Summit, MO 64082	7/13/11	7/13/11 to 7/13/12

Contractors Agreeing to Placement on the Public Works Debarment List as Part of an Agreement Relating to Criminal Pleas

Name of Contractor	Name of Officers	Address	Date of Conviction	Debarment Period
Rycoblake Corp.		4212 SE Saddlebrook Cir Lee's Summit, MO 64082		7/13/11 to 12/1/12
Gerald Chevalier		4212 SE Saddlebrook Cir Lee's Summit, MO 64082		7/13/11 to 12/1/12

Dated this 2 day of August 2011.

Carla Buschjost

Carla Buschjost, Director

ADDITION TO STATUTORY LIST OF CONTRACTORS BARRED FROM PUBLIC WORKS PROJECTS

The following is an addition to the list of contractor(s) who have been prosecuted and convicted of violating the Missouri Prevailing Wage Law, and whose Notice of Conviction has been filed with the Secretary of State pursuant to Section 290.330, RSMo. Under this statute, no public body is permitted to award a contract, directly or indirectly, for public works (1) to Mr. Saxon W. Johnson, (2) to any other contractor or subcontractor that is owned, operated or controlled by Mr. Saxon W. Johnson including The Tile Doctor or (3) to any other simulation of Mr. Saxon W. Johnson or of The Tile Doctor for a period of one year, or until September 2, 2012.

Name of Contractor	Name of Officers	Address	Date of Conviction	Debarment Period
Saxon W. Johnson DBA The Tile Doctor Case No. 10CA-CR01318 Cass County Cir. Ct.		10724 Haskins Ct Shawnee Mission, KS 66210	9/2/2011	9/2/2011-9/2/2012

Dated this 13 day of September 2011.

Carla Buschjost, Director

ADDITION TO STATUTORY LIST OF CONTRACTORS BARRED FROM PUBLIC WORKS PROJECTS

The following is an addition to the list of contractor(s) who have been prosecuted and convicted of violating the Missouri Prevailing Wage Law, and whose Notice of Conviction has been filed with the Secretary of State pursuant to Section 290.330, RSMo. Under this statute, no public body is permitted to award a contract, directly or indirectly, for public works (1) to Mr. Larry G. McElroy, (2) to any other contractor or subcontractor that is owned, operated or controlled by Mr. Larry G. McElroy including Blackhawk or (3) to any other simulation of Mr. Larry G. McElroy or of Blackhawk Electric for a period of one year, or until December 27, 2012.

Name of Contractor	Name of Officers	Address	Date of Conviction	Debarment Period
Larry G. McElroy DBA Blackhawk Electric Case No. 11CG-CR01157 Cape Girardeau County Cir. Ct.		254 E. Lake Dr., PO Box 248 Cape Girardeau, MO 63701	12/27/2011	12/27/2011-12/27/2012

Dated this 26 day of January, 2012.

Carla Buschjost, Director

ADDITION TO STATUTORY LIST OF CONTRACTORS BARRED FROM PUBLIC WORKS PROJECTS

The following is an addition to the list of contractor(s) who have been prosecuted and convicted of violating the Missouri Prevailing Wage Law, and whose Notice of Conviction has been filed with the Secretary of State pursuant to Section 290.330, RSMo. Under this statute, no public body is permitted to award a contract, directly or indirectly, for public works (1) to Mr. Norman Bass, (2) to any other contractor or subcontractor that is owned, operated or controlled by Mr. Norman Bass including Municipal Construction Incorporated or (3) to any other simulation of Mr. Norman Bass or of Municipal Construction Incorporated for a period of one year, or until February 1, 2013.

Name of Contractor	Name of Officers	Address	Date of Conviction	Debarment Period
Norman Bass DBA Municipal Construction Incorporated Case No. 12SO-CR00103 Scott County Cir. Ct.		10150 Hawthorne Ridge Goodrich, MI 48438	2/01/12	2/01/2012-2/01/2013

Dated this 17 day of February, 2012.

Carla Buschjost

Carla Buschjost, Director

The Secretary of State is required by sections 347.141 and 359.481, RSMo 2000, to publish dissolutions of limited liability companies and limited partnerships. The content requirements for the one-time publishing of these notices are prescribed by statute. This listing is published pursuant to these statutes. We request that documents submitted for publication in this section be submitted in camera ready 8 1/2" x 11" manuscript by email to dissolutions@sos.mo.gov.

NOTICE OF WINDING UP AND DISSOLUTION OF LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST HOPELAND PROPERTIES-EAU CLAIRE, LLC.

On February 27, 2012, Hopeland Properties-Eau Claire, LLC, a Missouri limited liability company (the "Company") filed its Notice of Winding Up and Articles of Termination with the Missouri Secretary of State. The Company requests that claimants against the Company present claims in writing to: James A. Fredericks, Attorney c/o Polsinelli Shughart PC, 100 South Fourth Street, Suite 1000, St. Louis, MO 63102. All claims must include (1) the name, address and telephone number of the claimant; (2) the amount claimed; (3) the basis of the claim; (4) the date on which the claim arose; and (5) documentation supporting the claim. All claims against the Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the publication of this notice.

NOTICE OF WINDING UP AND DISSOLUTION OF LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST HOPELAND WAREHOUSE, LLC.

On February 27, 2012, Hopeland Warehouse, LLC, a Missouri limited liability company (the "Company") filed its Notice of Winding Up and Articles of Termination with the Missouri Secretary of State. The Company requests that claimants against the Company present claims in writing to: James A. Fredericks, Attorney c/o Polsinelli Shughart PC, 100 South Fourth Street, Suite 1000, St. Louis, MO 63102. All claims must include (1) the name, address and telephone number of the claimant; (2) the amount claimed; (3) the basis of the claim; (4) the date on which the claim arose; and (5) documentation supporting the claim. All claims against the Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the publication of this notice.

NOTICE OF WINDING UP AND DISSOLUTION OF LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST KEYSTONE FAMILY GENERAL PARTNER, LLC.

On March 7, 2012, Keystone Family General Partner, LLC, a Missouri limited liability company (the "Company") filed its Notice of Winding Up and Articles of Termination with the Missouri Secretary of State. The Company requests that claimants against the Company present claims in writing to: Kim Brown, Attorney c/o Polsinelli Shughart PC, 100 South Fourth Street, Suite 1000, St. Louis, MO 63102. All claims must include (1) the name, address and telephone number of the claimant; (2) the amount claimed; (3) the basis of the claim; (4) the date on which the claim arose; and (5) documentation supporting the claim. All claims against the Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the publication of this notice.

NOTICE OF WINDING UP OF LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST MID-WEST PROPANE AND REFINED FUELS, L.L.C.

On March 1, 2012, Mid-West Propane and Refined Fuels, L.L.C., a Missouri limited liability company ("Company"), filed its Notice of Winding Up with the Missouri Secretary of State, effective on the filing date.

All persons and organizations must submit to Company, c/o Matthew M. Krohn, Esq., Andereck, Evans, Widger, Johnson & Lewis, L.L.C., 9th & Washington Streets, P.O. Box 547, Trenton, MO 64683, a written summary of any claims against Company, including: 1) claimant's name, address and telephone number, 2) amount of claim; 3) date(s) claim accrued (or will accrue); 4) brief description of the nature of the debt or the basis for the claim; and 5) if the claim is secured, and if so, the collateral used as security.

Because of the dissolution, any claims against the Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the last filing or publication of this Notice.

NOTICE OF WINDING UP OF LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST SOUTH BEACH TANNING FANTASY, L.L.C.

On March 13, 2012, SOUTH BEACH TANNING FANTASY, L.L.C., a Missouri limited liability company ("Company"), filed its Notice of Winding Up with the Missouri Secretary of State, effective on the filing date.

All persons and organizations must submit to Company, c/o C. Bradford Cantwell, Carnahan, Evans, Cantwell & Brown, P.C., 2805 S. Ingram Mill, Springfield, Missouri 65804, a written summary of any claims against Company, including: 1) claimant's name, address and telephone number; 2) amount of claim; 3) date(s) claim accrued (or will accrue); 4) brief description of the nature of the debt or the basis for the claim; and 5) if the claim is secured, and if so, the collateral used as security.

Because of the dissolution, any claims against Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the last of filing or publication of this Notice.

NOTICE OF DISSOULUTION OF

LIMITED LIABILITY COMPANY

TO ALL CREDITORS OF AND ALL

CLAIMANTS AGAINST

THE HAMPTONS FLOORING COMPANY, L.L.C.

On March 8,2012, The Hamptons Flooring Company, L.L.C., a Missouri limited liability company (the "Company") filed a notice of Winding Up with the Missouri Secretary of State. Claims against the Company should be mailed to Scott Perkinson,1274 Bentoak Ct., Kirkwood, MO 63122. All claims must include the following information:

1. Name & address of the claimant;
2. The amount of the claim;
3. Basis for the claim; and
4. Documentation for the claim.

All claims against the Company will be barred unless a proceeding to enforce the claim is commenced within three years after the publication of this notice.

This cumulative table gives you the latest status of rules. It contains citations of rulemakings adopted or proposed after deadline for the monthly Update Service to the *Code of State Regulations*, citations are to volume and page number in the *Missouri Register*, except for material in this issue. The first number in the table cite refers to the volume number or the publication year—30 (2005) and 31 (2006). MoReg refers to *Missouri Register* and the numbers refer to a specific *Register* page, R indicates a rescission, W indicates a withdrawal, S indicates a statement of actual cost, T indicates an order terminating a rule, N.A. indicates not applicable, RAN indicates a rule action notice, RUC indicates a rule under consideration, and F indicates future effective date.

Rule Number	Agency	Emergency	Proposed	Order	In Addition
	OFFICE OF ADMINISTRATION				
1 CSR 10	State Officials' Salary Compensation Schedule				35 MoReg 1815
	DEPARTMENT OF AGRICULTURE				
2 CSR 70-25.065	Plant Industries		This Issue		
2 CSR 70-30.110	Plant Industries		This Issue		
2 CSR 70-30.115	Plant Industries		This Issue		
2 CSR 80-1.010	State Milk Board		This Issue		
2 CSR 80-2.010	State Milk Board		37 MoReg 505R 37 MoReg 505		
2 CSR 80-2.020	State Milk Board		This Issue		
2 CSR 80-2.030	State Milk Board		This Issue		
2 CSR 80-2.040	State Milk Board		This Issue		
2 CSR 80-2.050	State Milk Board		This Issue		
2 CSR 80-2.060	State Milk Board		This Issue		
2 CSR 80-2.070	State Milk Board		This Issue		
2 CSR 80-2.080	State Milk Board		This Issue		
2 CSR 80-2.091	State Milk Board		This Issue		
2 CSR 80-2.101	State Milk Board		This Issue		
2 CSR 80-2.110	State Milk Board		This Issue		
2 CSR 80-2.121	State Milk Board		This Issue		
2 CSR 80-2.130	State Milk Board		This Issue		
2 CSR 80-2.141	State Milk Board		This Issue		
2 CSR 80-2.151	State Milk Board		This Issue		
2 CSR 80-2.161	State Milk Board		This Issue		
2 CSR 80-2.170	State Milk Board		This Issue		
2 CSR 80-2.180	State Milk Board		This Issue		
2 CSR 80-4.010	State Milk Board		This Issue		
2 CSR 90-10	Weights and Measures				36 MoReg 1762
	DEPARTMENT OF CONSERVATION				
3 CSR 10-6.415	Conservation Commission		This Issue		
3 CSR 10-7.455	Conservation Commission		36 MoReg 2161	37 MoReg 51	37 MoReg 118
3 CSR 10-11.120	Conservation Commission		This Issue		
3 CSR 10-11.180	Conservation Commission		This Issue		
3 CSR 10-12.109	Conservation Commission		This Issue		
3 CSR 10-12.110	Conservation Commission		This Issue		
3 CSR 10-12.125	Conservation Commission		This Issue		
	DEPARTMENT OF ECONOMIC DEVELOPMENT				
4 CSR 170-7.010	Missouri Housing Development Commission		37 MoReg 7R		
4 CSR 170-7.020	Missouri Housing Development Commission		37 MoReg 7R		
4 CSR 170-7.030	Missouri Housing Development Commission		37 MoReg 8R		
4 CSR 170-7.040	Missouri Housing Development Commission		37 MoReg 8R		
4 CSR 170-7.050	Missouri Housing Development Commission		37 MoReg 8R		
4 CSR 170-7.100	Missouri Housing Development Commission		37 MoReg 8		
4 CSR 170-7.200	Missouri Housing Development Commission		37 MoReg 9		
4 CSR 170-7.300	Missouri Housing Development Commission		37 MoReg 10		
4 CSR 170-7.400	Missouri Housing Development Commission		37 MoReg 11		
4 CSR 170-7.500	Missouri Housing Development Commission		37 MoReg 12		
4 CSR 170-7.600	Missouri Housing Development Commission		37 MoReg 14		
4 CSR 240-4.020	Public Service Commission		36 MoReg 2230	37 MoReg 527W	
4 CSR 240-20.065	Public Service Commission		37 MoReg 315		
	DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION				
5 CSR 20-100.200	Division of Learning Services		37 MoReg 507		
5 CSR 20-100.250	Division of Learning Services		37 MoReg 333		
5 CSR 20-300.120	Division of Learning Services		N.A.	37 MoReg 527	
5 CSR 20-400.150	Division of Learning Services		37 MoReg 509		
5 CSR 20-400.160	Division of Learning Services		37 MoReg 509		
5 CSR 20-400.170	Division of Learning Services		37 MoReg 510		
5 CSR 20-400.180	Division of Learning Services		37 MoReg 510		
5 CSR 20-400.190	Division of Learning Services		37 MoReg 511		
5 CSR 20-400.200	Division of Learning Services		37 MoReg 511		
5 CSR 20-400.250	Division of Learning Services		37 MoReg 511		
5 CSR 20-400.260	Division of Learning Services		37 MoReg 512		
5 CSR 20-400.280	Division of Learning Services		37 MoReg 512		
5 CSR 50-378.100	Division of School Improvement		37 MoReg 97R		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
5 CSR 50-380.010	Division of School Improvement		37 MoReg 97R		
5 CSR 50-390.010	Division of School Improvement		37 MoReg 97R		
	DEPARTMENT OF TRANSPORTATION				
7 CSR 10-25.010	Missouri Highways and Transportation Commission				37 MoReg 540
	DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS				
8 CSR 10-5.030	Division of Employment Security		37 MoReg 334		
	DEPARTMENT OF MENTAL HEALTH				
9 CSR 10-5.240	Director, Department of Mental Health	37 MoReg 147	36 MoReg 2369	This Issue	
9 CSR 10-31.040	Director, Department of Mental Health		37 MoReg 335		
9 CSR 30-4.030	Certification Standards		37 MoReg 15		
9 CSR 30-4.034	Certification Standards		37 MoReg 17		
9 CSR 30-4.035	Certification Standards		37 MoReg 18		
9 CSR 30-4.039	Certification Standards		37 MoReg 19		
9 CSR 30-4.042	Certification Standards		37 MoReg 20		
9 CSR 30-4.043	Certification Standards		37 MoReg 20		
9 CSR 30-4.046	Certification Standards		37 MoReg 22		
9 CSR 45-2.010	Division of Mental Retardation and Developmental Disabilities		37 MoReg 337		
9 CSR 45-2.015	Division of Mental Retardation and Developmental Disabilities		37 MoReg 352		
9 CSR 45-2.017	Division of Mental Retardation and Developmental Disabilities		37 MoReg 355		
9 CSR 45-2.020	Division of Mental Retardation and Developmental Disabilities		37 MoReg 377		
	DEPARTMENT OF NATURAL RESOURCES				
10 CSR 10-2.385	Air Conservation Commission		36 MoReg 2520		
10 CSR 10-5.040	Air Conservation Commission		36 MoReg 2232	This Issue	
10 CSR 10-5.130	Air Conservation Commission		36 MoReg 2233	This Issue	
10 CSR 10-5.385	Air Conservation Commission		36 MoReg 2521		
10 CSR 10-5.455	Air Conservation Commission		36 MoReg 2233	This Issue	
10 CSR 10-5.490	Air Conservation Commission		36 MoReg 2234	This Issue	
10 CSR 10-6.020	Air Conservation Commission		36 MoReg 2246	This Issue	
10 CSR 10-6.060	Air Conservation Commission		37 MoReg 379		
10 CSR 10-6.065	Air Conservation Commission		37 MoReg 383		
10 CSR 10-6.260	Air Conservation Commission		37 MoReg 388		
10 CSR 10-6.310	Air Conservation Commission		36 MoReg 2260	This Issue	
10 CSR 10-6.400	Air Conservation Commission		36 MoReg 2269	This Issue	
10 CSR 10-6.410	Air Conservation Commission		37 MoReg 392		
10 CSR 20-6.010	Clean Water Commission	36 MoReg 1892	36 MoReg 1895	37 MoReg 443	
10 CSR 20-6.100	Clean Water Commission		36 MoReg 2906R 36 MoReg 2906 37 MoReg 393R 37 MoReg 394		
10 CSR 20-6.300	Clean Water Commission		36 MoReg 1909	37 MoReg 445	
10 CSR 20-7.031	Clean Water Commission		36 MoReg 2521		
10 CSR 20-8.300	Clean Water Commission		36 MoReg 1927	37 MoReg 458	
10 CSR 23-1.050	Division of Geology and Land Survey		36 MoReg 2178	37 MoReg 466	
10 CSR 60-5.010	Safe Drinking Water Commission		36 MoReg 2374	37 MoReg 528	
10 CSR 60-7.020	Safe Drinking Water Commission		36 MoReg 2375	37 MoReg 529	
10 CSR 60-8.030	Safe Drinking Water Commission		36 MoReg 2380	37 MoReg 529	
10 CSR 60-15.010	Safe Drinking Water Commission		36 MoReg 2380	37 MoReg 529	
10 CSR 60-15.020	Safe Drinking Water Commission		36 MoReg 2381	37 MoReg 529	
10 CSR 60-15.040	Safe Drinking Water Commission		36 MoReg 2384	37 MoReg 529	
10 CSR 60-15.050	Safe Drinking Water Commission		36 MoReg 2384	37 MoReg 530	
10 CSR 60-15.060	Safe Drinking Water Commission		36 MoReg 2385R 36 MoReg 2385	37 MoReg 530R 37 MoReg 530	
10 CSR 60-15.070	Safe Drinking Water Commission		36 MoReg 2391	37 MoReg 530	
10 CSR 60-15.080	Safe Drinking Water Commission		36 MoReg 2393	37 MoReg 530	
10 CSR 60-15.090	Safe Drinking Water Commission		36 MoReg 2394	37 MoReg 531	
10 CSR 140-8.010	Division of Energy		37 MoReg 513		
	DEPARTMENT OF PUBLIC SAFETY				
11 CSR 10-12.010	Adjutant General *(Changed to 11 CSR 30-13.010)*		37 MoReg 152		
11 CSR 10-12.020	Adjutant General *(Changed to 11 CSR 30-13.020)*		37 MoReg 152		
11 CSR 10-12.030	Adjutant General *(Changed to 11 CSR 30-13.030)*		37 MoReg 153		
11 CSR 10-12.040	Adjutant General *(Changed to 11 CSR 30-13.040)*		37 MoReg 153		
11 CSR 10-12.050	Adjutant General *(Changed to 11 CSR 30-13.050)*		37 MoReg 153		
11 CSR 10-12.060	Adjutant General *(Changed to 11 CSR 30-13.060)*		37 MoReg 154		
11 CSR 30-12.010	Office of the Director	37 MoReg 93	37 MoReg 98		

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11 CSR 30-13.010	Office of the Director *(Changed from 11 CSR 10-12.010)*		37 MoReg 152		
11 CSR 30-13.020	Office of the Director *(Changed from 11 CSR 10-12.020)*		37 MoReg 152		
11 CSR 30-13.030	Office of the Director *(Changed from 11 CSR 10-12.030)*		37 MoReg 153		
11 CSR 30-13.040	Office of the Director *(Changed from 11 CSR 10-12.040)*		37 MoReg 153		
11 CSR 30-13.050	Office of the Director *(Changed from 11 CSR 10-12.050)*		37 MoReg 153		
11 CSR 30-13.060	Office of the Director *(Changed from 11 CSR 10-12.060)*		37 MoReg 154		
11 CSR 30-13.070	Office of the Director		37 MoReg 155		
11 CSR 30-13.080	Office of the Director		37 MoReg 156		
11 CSR 30-13.090	Office of the Director		37 MoReg 156		
11 CSR 30-13.100	Office of the Director		37 MoReg 156		
11 CSR 30-13.110	Office of the Director		37 MoReg 157		
11 CSR 45-1.015	Missouri Gaming Commission		36 MoReg 2270	37 MoReg 531	
11 CSR 45-1.080	Missouri Gaming Commission		36 MoReg 2270	37 MoReg 531	
11 CSR 45-5.030	Missouri Gaming Commission		36 MoReg 2270	37 MoReg 531	
11 CSR 45-5.065	Missouri Gaming Commission		36 MoReg 2271	37 MoReg 532	
11 CSR 45-5.185	Missouri Gaming Commission		37 MoReg 407		
11 CSR 45-8.130	Missouri Gaming Commission		37 MoReg 408		
11 CSR 45-9.106	Missouri Gaming Commission		37 MoReg 410		
11 CSR 45-9.108	Missouri Gaming Commission		36 MoReg 2687		
11 CSR 45-9.118	Missouri Gaming Commission		37 MoReg 106		
11 CSR 45-9.120	Missouri Gaming Commission		37 MoReg 410		
11 CSR 45-12.090	Missouri Gaming Commission		36 MoReg 2271	37 MoReg 532	
	DEPARTMENT OF REVENUE				
12 CSR 10-23.446	Director of Revenue		37 MoReg 237		
12 CSR 10-26.210	Director of Revenue		37 MoReg 410		
12 CSR 10-41.010	Director of Revenue	36 MoReg 2455	36 MoReg 2687	37 MoReg 467	
12 CSR 30-4.010	State Tax Commission		37 MoReg 157		
	DEPARTMENT OF SOCIAL SERVICES				
13 CSR 40-2.395	Family Support Division		37 MoReg 517		
13 CSR 70-3.230	MO HealthNet Division		37 MoReg 23		
13 CSR 70-3.240	MO HealthNet Division		37 MoReg 106		
13 CSR 70-4.110	MO HealthNet Division		37 MoReg 111		
13 CSR 70-10.160	MO HealthNet Division		37 MoReg 441		
13 CSR 70-15.200	MO HealthNet Division		37 MoReg 27R		
13 CSR 70-35.010	MO HealthNet Division		36 MoReg 2273	37 MoReg 532	
	DEPARTMENT OF CORRECTIONS				
14 CSR 80-3.010	State Board of Probation and Parole		36 MoReg 2695	37 MoReg 536	
14 CSR 80-3.020	State Board of Probation and Parole		36 MoReg 2697	37 MoReg 536	
14 CSR 80-4.010	State Board of Probation and Parole		37 MoReg 160		
14 CSR 80-4.020	State Board of Probation and Parole		37 MoReg 160		
14 CSR 80-4.030	State Board of Probation and Parole		37 MoReg 161		
14 CSR 80-5.010	State Board of Probation and Parole		36 MoReg 2697	37 MoReg 536	
14 CSR 80-5.020	State Board of Probation and Parole		36 MoReg 2698	37 MoReg 537	
	ELECTED OFFICIALS				
15 CSR 30-200.010	Secretary of State		36 MoReg 2698	37 MoReg 467	
15 CSR 30-200.020	Secretary of State		36 MoReg 2699	37 MoReg 467	
15 CSR 40-3.020	State Auditor		37 MoReg 518		
15 CSR 40-3.030	State Auditor		37 MoReg 518		
15 CSR 40-5.010	State Auditor		37 MoReg 519R		
15 CSR 60-13.060	Attorney General		36 MoReg 2274		
	RETIREMENT SYSTEMS				
16 CSR 10-5.030	The Public School Retirement System of Missouri		37 MoReg 163		
16 CSR 10-6.090	The Public School Retirement System of Missouri		37 MoReg 164		
16 CSR 50-2.010	The County Employees' Retirement Fund		37 MoReg 165		
16 CSR 50-2.160	The County Employees' Retirement Fund		37 MoReg 165		
16 CSR 50-3.010	The County Employees' Retirement Fund		37 MoReg 165		
	DEPARTMENT OF HEALTH AND SENIOR SERVICES				
19 CSR 10-10	Office of the Director				36 MoReg 1700
19 CSR 20-26.030	Division of Community and Public Health		37 MoReg 519R		
19 CSR 20-26.040	Division of Community and Public Health		37 MoReg 519		
19 CSR 20-28.010	Division of Community and Public Health		37 MoReg 27		
19 CSR 20-28.040	Division of Community and Public Health		37 MoReg 38		
19 CSR 30-1	Division of Regulation and Licensure				36 MoReg 1702
19 CSR 30-20	Division of Regulation and Licensure				36 MoReg 1704
19 CSR 30-40.365	Division of Regulation and Licensure		37 MoReg 523		
19 CSR 30-70.620	Division of Regulation and Licensure		37 MoReg 44		

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19 CSR 30-70.630	Division of Regulation and Licensure		37 MoReg 44		
19 CSR 30-81.015	Division of Regulation and Licensure		37 MoReg 523R		
19 CSR 30-85.022	Division of Regulation and Licensure		This Issue		
19 CSR 30-86.022	Division of Regulation and Licensure		This Issue		
19 CSR 30-86.043	Division of Regulation and Licensure		37 MoReg 524		
19 CSR 30-86.047	Division of Regulation and Licensure		37 MoReg 525		
19 CSR 30-88.020	Division of Regulation and Licensure		This Issue		
19 CSR 60-50	Missouri Health Facilities Review Committee				37 MoReg 472 37 MoReg 541 37 MoReg 541 37 MoReg 541
	DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION				
20 CSR	Applied Behavior Analysis Maximum Benefit				37 MoReg 472
20 CSR	Construction Claims Binding Arbitration Cap				36 MoReg 192 37 MoReg 62
20 CSR	Sovereign Immunity Limits				37 MoReg 62
20 CSR	State Legal Expense Fund Cap				36 MoReg 192 37 MoReg 62
20 CSR 100-5.020	Insurer Conduct	36 MoReg 2897	36 MoReg 2920 37 MoReg 166		
20 CSR 200-12.030	Insurance Solvency and Company Regulation		37 MoReg 238		
20 CSR 200-18.030	Insurance Solvency and Company Regulation	37 MoReg 150	37 MoReg 168		
20 CSR 700-1.160	Insurance Licensing	37 MoReg 150	37 MoReg 171		
20 CSR 2010-2.022	Missouri State Board of Accountancy		37 MoReg 112		
20 CSR 2030-2.040	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		36 MoReg 2701	This Issue	
20 CSR 2030-2.050	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		36 MoReg 2701	This Issue	
20 CSR 2030-11.015	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		36 MoReg 2701	This Issue	
20 CSR 2030-11.035	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		36 MoReg 2702	This Issue	
20 CSR 2030-14.050	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		36 MoReg 2702R	This IssueR	
20 CSR 2110-2.010	Missouri Dental Board		This Issue		
20 CSR 2110-2.030	Missouri Dental Board		This Issue		
20 CSR 2110-2.050	Missouri Dental Board		This Issue		
20 CSR 2110-2.070	Missouri Dental Board		This Issue		
20 CSR 2115-1.040	State Committee of Dietitians	36 MoReg 2899	36 MoReg 2922	37 MoReg 537	
20 CSR 2115-2.010	State Committee of Dietitians		36 MoReg 2925	37 MoReg 537	
20 CSR 2115-2.020	State Committee of Dietitians		36 MoReg 2925	37 MoReg 537	
20 CSR 2115-2.040	State Committee of Dietitians		36 MoReg 2925	37 MoReg 537	
20 CSR 2115-2.045	State Committee of Dietitians		36 MoReg 2926	37 MoReg 537	
20 CSR 2145-1.040	Missouri Board of Geologist Registration		37 MoReg 45	This Issue	
20 CSR 2150-1.011	State Board of Registration for the Healing Arts		37 MoReg 173R 37 MoReg 173		
20 CSR 2150-2.150	State Board of Registration for the Healing Arts		36 MoReg 2703	37 MoReg 467	
20 CSR 2150-3.010	State Board of Registration for the Healing Arts		36 MoReg 2705	37 MoReg 467	
20 CSR 2150-3.203	State Board of Registration for the Healing Arts		37 MoReg 178		
20 CSR 2150-4.201	State Board of Registration for the Healing Arts		37 MoReg 178		
20 CSR 2150-4.203	State Board of Registration for the Healing Arts		37 MoReg 179		
20 CSR 2150-4.205	State Board of Registration for the Healing Arts		37 MoReg 180		
20 CSR 2150-5.026	State Board of Registration for the Healing Arts		37 MoReg 241		
20 CSR 2150-5.028	State Board of Registration for the Healing Arts		37 MoReg 241		
20 CSR 2150-6.010	State Board of Registration for the Healing Arts		36 MoReg 2707	37 MoReg 468	
20 CSR 2150-6.020	State Board of Registration for the Healing Arts		36 MoReg 2707	37 MoReg 468	
20 CSR 2150-6.040	State Board of Registration for the Healing Arts		36 MoReg 2709	37 MoReg 468	
20 CSR 2150-6.062	State Board of Registration for the Healing Arts		36 MoReg 2709	37 MoReg 468	
20 CSR 2165-2.050	Board of Examiners for Hearing Instrument Specialists		37 MoReg 113		
20 CSR 2205-3.010	Missouri Board of Occupational Therapy		37 MoReg 180		
20 CSR 2205-3.020	Missouri Board of Occupational Therapy		37 MoReg 184		
20 CSR 2205-3.030	Missouri Board of Occupational Therapy		37 MoReg 187		
20 CSR 2220-2.145	State Board of Pharmacy		37 MoReg 190		
20 CSR 2220-6.060	State Board of Pharmacy		37 MoReg 244		
20 CSR 2220-6.070	State Board of Pharmacy		37 MoReg 245		
20 CSR 2220-6.080	State Board of Pharmacy		37 MoReg 251		
20 CSR 2231-2.010	Division of Professional Registration		37 MoReg 48		
20 CSR 2233-1.010	State Committee of Marital and Family Therapists		36 MoReg 2926	37 MoReg 468	
20 CSR 2233-1.030	State Committee of Marital and Family Therapists		36 MoReg 2926	37 MoReg 469	
20 CSR 2233-1.040	State Committee of Marital and Family Therapists	36 MoReg 2900	36 MoReg 2927	37 MoReg 469	

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20 CSR 2233-1.050	State Committee of Marital and Family Therapists		36 MoReg 2930	37 MoReg 469	
20 CSR 2233-2.020	State Committee of Marital and Family Therapists		36 MoReg 2930	37 MoReg 538	
20 CSR 2233-2.021	State Committee of Marital and Family Therapists		36 MoReg 2932R 36 MoReg 2932	37 MoReg 538R 37 MoReg 538	
20 CSR 2233-2.030	State Committee of Marital and Family Therapists		36 MoReg 2933	37 MoReg 538	
20 CSR 2233-2.050	State Committee of Marital and Family Therapists		36 MoReg 2934	37 MoReg 538	
20 CSR 2233-3.010	State Committee of Marital and Family Therapists		36 MoReg 2935	37 MoReg 539	
20 CSR 2250-4.070	Missouri Real Estate Commission		36 MoReg 2709	37 MoReg 469	
20 CSR 2250-7.070	Missouri Real Estate Commission		36 MoReg 2710	37 MoReg 469	
20 CSR 2250-8.030	Missouri Real Estate Commission		36 MoReg 2710	37 MoReg 469	
20 CSR 2250-8.120	Missouri Real Estate Commission		36 MoReg 2711	37 MoReg 470	
20 CSR 2270-1.021	Missouri Veterinary Medical Board		37 MoReg 190		
20 CSR 2270-2.031	Missouri Veterinary Medical Board		37 MoReg 191		
20 CSR 2270-2.041	Missouri Veterinary Medical Board		37 MoReg 195		
20 CSR 2270-3.020	Missouri Veterinary Medical Board		37 MoReg 199		
	MISSOURI FAMILY TRUST				
21 CSR 10-1.010	Director and Board of Trustees	36 MoReg 2900R	36 MoReg 2936R	37 MoReg 470R	
21 CSR 10-1.020	Director and Board of Trustees	36 MoReg 2901R	36 MoReg 2936R	37 MoReg 470R	
21 CSR 10-1.030	Director and Board of Trustees	36 MoReg 2902R	36 MoReg 2936R	37 MoReg 470R	
21 CSR 10-2.010	Director and Board of Trustees	36 MoReg 2902R	36 MoReg 2936R	37 MoReg 470R	
21 CSR 10-3.010	Director and Board of Trustees	36 MoReg 2903R	36 MoReg 2937R	37 MoReg 470R	
21 CSR 10-4.010	Director and Board of Trustees	36 MoReg 2904R	36 MoReg 2937R	37 MoReg 471R	
21 CSR 10-4.020	Director and Board of Trustees	36 MoReg 2905R	36 MoReg 2937R	37 MoReg 471R	
	MISSOURI CONSOLIDATED HEALTH CARE PLAN				
22 CSR 10-1.010	Health Care Plan		36 MoReg 2711	This Issue	
22 CSR 10-1.020	Health Care Plan		36 MoReg 2712	This Issue	
22 CSR 10-2.010	Health Care Plan	36 MoReg 2455	36 MoReg 2712	This Issue	
22 CSR 10-2.020	Health Care Plan	36 MoReg 2463R 36 MoReg 2463	36 MoReg 2719R 36 MoReg 2720	This IssueR This Issue	
22 CSR 10-2.030	Health Care Plan	36 MoReg 2471	36 MoReg 2730	This Issue	
22 CSR 10-2.045	Health Care Plan	36 MoReg 2472	36 MoReg 2734	This Issue	
22 CSR 10-2.051	Health Care Plan	36 MoReg 2473	36 MoReg 2735	This Issue	
22 CSR 10-2.052	Health Care Plan	36 MoReg 2475	36 MoReg 2739	This Issue	
22 CSR 10-2.053	Health Care Plan	36 MoReg 2476	36 MoReg 2742	This Issue	
22 CSR 10-2.054	Health Care Plan		36 MoReg 2746	This Issue	
22 CSR 10-2.055	Health Care Plan	36 MoReg 2477R 36 MoReg 2478	36 MoReg 2749R 36 MoReg 2749	This IssueR This Issue	
22 CSR 10-2.060	Health Care Plan		36 MoReg 2756	This Issue	
22 CSR 10-2.070	Health Care Plan		36 MoReg 2760	This Issue	
22 CSR 10-2.075	Health Care Plan	36 MoReg 2482	36 MoReg 2761	This Issue	
22 CSR 10-2.090	Health Care Plan	36 MoReg 2486	36 MoReg 2764	This Issue	
22 CSR 10-2.091	Health Care Plan	36 MoReg 2488	36 MoReg 2769	37 MoReg 471	
22 CSR 10-2.092	Health Care Plan		36 MoReg 2770R 36 MoReg 2770	This IssueR This Issue	
22 CSR 10-2.093	Health Care Plan		36 MoReg 2772R 36 MoReg 2772	This IssueR This Issue	
22 CSR 10-2.094	Health Care Plan	36 MoReg 2489	36 MoReg 2774	37 MoReg 471	
22 CSR 10-2.095	Health Care Plan	36 MoReg 2490	36 MoReg 2776	This Issue	
22 CSR 10-2.100	Health Care Plan	36 MoReg 2491	36 MoReg 2778	This Issue	
22 CSR 10-3.010	Health Care Plan	36 MoReg 2491	36 MoReg 2778	This Issue	
22 CSR 10-3.020	Health Care Plan	36 MoReg 2498R 36 MoReg 2499	36 MoReg 2785R 36 MoReg 2785	This IssueR This Issue	
22 CSR 10-3.030	Health Care Plan		36 MoReg 2794	This Issue	
22 CSR 10-3.045	Health Care Plan	36 MoReg 2505	36 MoReg 2798	This Issue	
22 CSR 10-3.053	Health Care Plan	36 MoReg 2506	36 MoReg 2799	This Issue	
22 CSR 10-3.054	Health Care Plan	36 MoReg 2507	36 MoReg 2803	This Issue	
22 CSR 10-3.055	Health Care Plan		36 MoReg 2806	This Issue	
22 CSR 10-3.056	Health Care Plan		36 MoReg 2809	This Issue	
22 CSR 10-3.057	Health Care Plan	36 MoReg 2508R 36 MoReg 2509	36 MoReg 2812R 36 MoReg 2812	This IssueR This Issue	
22 CSR 10-3.060	Health Care Plan		36 MoReg 2819	This Issue	
22 CSR 10-3.070	Health Care Plan		36 MoReg 2823	This Issue	
22 CSR 10-3.075	Health Care Plan	36 MoReg 2513	36 MoReg 2824	This Issue	
22 CSR 10-3.090	Health Care Plan	36 MoReg 2516	36 MoReg 2827	This Issue	
22 CSR 10-3.092	Health Care Plan		36 MoReg 2832R 36 MoReg 2832	This IssueR This Issue	
22 CSR 10-3.093	Health Care Plan		36 MoReg 2835R 36 MoReg 2835	This IssueR This Issue	
22 CSR 10-3.100	Health Care Plan	36 MoReg 2519	36 MoReg 2837	This Issue	

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Department of Mental Health				
Director, Department of Mental Health				
9 CSR 10-5.240	Health Home	37 MoReg 147	Jan. 1, 2012	June 28, 2012
Department of Natural Resources				
Clean Water Commission				
10 CSR 20-6.010	Construction and Operating Permits	36 MoReg 1892	Oct. 31, 2011	April 27, 2012
Department of Public Safety				
Office of the Director				
11 CSR 30-12.010	Payment for Sexual Assault Forensic Examinations	37 MoReg 93	Dec. 17, 2011	June 13, 2012
Department of Revenue				
Director of Revenue				
12 CSR 10-41.010	Annual Adjusted Rate of Interest	36 MoReg 2455	Jan. 1, 2012	June 28, 2012
Elected Officials				
Treasurer				
15 CSR 50-4.030	Missouri MOST 529 Matching Grant Program	May 15, 2012 Issue	April 15, 2012	Jan. 23, 2013
Department of Insurance, Financial Institutions and Professional Registration				
Insurer Conduct				
20 CSR 100-5.020	Grievance Review Procedures	36 MoReg 2897	Jan. 1, 2012	June 28, 2012
Insurance Solvency and Company Regulations				
20 CSR 200-18.030	Licensure of Motor Vehicle Extended Service Contract Producers	37 MoReg 150	Jan. 9, 2012	July 6, 2012
Insurance Licensing				
20 CSR 700-1.160	Licensing and Authorization of Portable Electronics Insurance Producers and Related Entities	37 MoReg 150	Jan. 9, 2012	July 6, 2012
State Committee of Dietitians				
20 CSR 2115-1.040	Fees	36 MoReg 2899	Dec. 20, 2011	June 16, 2012
State Committee of Marital and Family Therapists				
20 CSR 2233-1.040	Fees	36 MoReg 2900	Nov. 25, 2011	May 22, 2012
Missouri Family Trust				
Director and Board of Trustees				
21 CSR 10-1.010	General Organization	36 MoReg 2900	Nov. 25, 2011	May 22, 2012
21 CSR 10-1.020	Definitions	36 MoReg 2901	Nov. 25, 2011	May 22, 2012
21 CSR 10-1.030	Meetings of the Board of Trustees	36 MoReg 2902	Nov. 25, 2011	May 22, 2012
21 CSR 10-2.010	Terms and Conditions of the Missouri Family Trust	36 MoReg 2902	Nov. 25, 2011	May 22, 2012
21 CSR 10-3.010	Charitable Trust Regulations	36 MoReg 2903	Nov. 25, 2011	May 22, 2012
21 CSR 10-4.010	Administrative Fees for Missouri Family Trust Accounts	36 MoReg 2904	Nov. 25, 2011	May 22, 2012
21 CSR 10-4.020	Administrative Fees for the Charitable Trust	36 MoReg 2905	Nov. 25, 2011	May 22, 2012
Missouri Consolidated Health Care Plan				
Health Care Plan				
22 CSR 10-2.010	Definitions	36 MoReg 2455	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.020	General Membership Provisions (Rescission)	36 MoReg 2463	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.020	General Membership Provisions	36 MoReg 2463	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.030	Contributions	36 MoReg 2471	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.045	Plan Utilization Review Policy	36 MoReg 2472	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.051	PPO 300 Plan Benefit Provisions and Covered Charges	36 MoReg 2473	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.052	PPO 600 Plan Benefit Provisions and Covered Charges	36 MoReg 2475	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.053	High Deductible Health Plan Benefit Provisions and Covered Charges	36 MoReg 2476	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.055	Medical Plan Benefit Provisions and Covered Charges (Rescission)	36 MoReg 2477	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.055	Medical Plan Benefit Provisions and Covered Charges	36 MoReg 2478	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.075	Review and Appeals Procedure	36 MoReg 2482	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.090	Pharmacy Benefit Summary	36 MoReg 2486	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.091	Wellness Program Coverage, Provisions, and Limitations	36 MoReg 2488	Nov. 25, 2011	May 22, 2012
22 CSR 10-2.094	Tobacco-Free Incentive Provisions and Limitations	36 MoReg 2489	Nov. 25, 2011	May 22, 2012

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22 CSR 10-2.095	TRICARE Supplement Plan	36 MoReg 2490	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.100	Fully-Insured Medical Plan Provisions	36 MoReg 2491	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.010	Definitions	36 MoReg 2491	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.020	Subscriber Agreement and General Membership Provisions (Rescission)	36 MoReg 2498	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.020	General Membership Provisions	36 MoReg 2499	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.045	Plan Utilization Review Policy	36 MoReg 2505	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.053	PPO 1000 Plan Benefit Provisions and Covered Charges	36 MoReg 2506	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.054	PPO 2000 Plan Benefit Provisions and Covered Charges	36 MoReg 2507	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.057	Medical Plan Benefit Provisions and Covered Charges (Rescission)	36 MoReg 2508	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.057	Medical Plan Benefit Provisions and Covered Charges	36 MoReg 2509	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.075	Review and Appeals Procedure	36 MoReg 2513	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.090	Pharmacy Benefit Summary	36 MoReg 2516	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.100	Fully-Insured Medical Plan Provisions	36 MoReg 2519	Jan. 1, 2012	June 28, 2012

Executive Orders	Subject Matter	Filed Date	Publication
	2012		
12-05	Extends Executive Orders 11-06, 12-03, 11-07, 11-11, 11-14, and 12-04 until June 1, 2012	March 13, 2012	This Issue
12-04	Activates the state militia in response to severe weather that began on February 28, 2012	Feb. 29, 2012	37 MoReg 503
12-03	Declares a state of emergency and directs that the Missouri State Emergency Operations Plan be activated due to the severe weather that began on February 28, 2012	Feb. 29, 2012	37 MoReg 501
12-02	Orders the transfer of all authority, powers, and duties of all remaining audit and compliance responsibilities relating to Medicaid Title XIX, SCHIP Title XXI, and Medicaid Waiver programs from the Dept. of Health and Senior Services and the Dept. of Mental Health to the Dept. of Social Services effective Aug. 28, 2012, unless disapproved within sixty days of its submission to the Second Regular Session of the 96th General Assembly	Jan. 23, 2012	37 MoReg 313
12-01	Designates members of the governor's staff to have supervisory authority over certain departments, divisions, and agencies	Jan. 23, 2012	37 MoReg 311
	2011		
11-25	Extends the declaration of emergency contained in Executive Order 11-06 (and extended by Executive Orders 11-09, 11-19, and 11-23) until March 15, 2012, unless extended in whole or part by subsequent order. Further Executive Orders 11-07, 11-11, and 11-14 are extended until March 15, 2012, unless extended in whole or part by subsequent order	Dec. 14, 2011	37 MoReg 95
11-24	Designates members of the governor's staff to have supervisory authority over certain departments, divisions, and agencies	Nov. 18, 2011	37 MoReg 5
11-23	Extends Executive Order 11-20 until October 15, 2011, and extends Executive Orders 11-06, 11-07, 11-08, 11-11, 11-14, and 11-18 until December 18, 2011	Sept. 13, 2011	36 MoReg 2157
11-22	Designates members of the governor's staff to have supervisory authority over certain departments, divisions, and agencies	July 26, 2011	36 MoReg 1979
11-21	Authorizes the Joplin Public School system to immediately begin to retrofit, equip, and furnish various buildings to house students during the 2011-2012 school year without requiring advertisements for bids	June 17, 2011	36 MoReg 1800
11-20	Extends certain terms of Executive Order 11-12 to help Missouri citizens impacted by the Joplin tornado of April 22, 2011	June 17, 2011	36 MoReg 1798
11-19	Extends certain terms of Executive Orders 11-06, 11-07, 11-08, 11-10, 11-11, 11-13, 11-14, 11-15, 11-16, and 11-18 until September 15, 2011	June 17, 2011	36 MoReg 1796
11-18	Activates the state militia in response to flooding events occurring and threatening along the Missouri River	June 8, 2011	36 MoReg 1739
11-17	Establishes the State of Missouri Resource, Recovery & Rebuilding Center in the City of Joplin in response to a tornado that struck there on May 22, 2011	June 7, 2011	36 MoReg 1737
11-16	Authorizes the Joplin Public Schools to immediately begin to retrofit and furnish warehouse and retail structures to house district programs displaced by the tornado and severe storms on May 22, 2011, without requiring advertisements for bids	June 3, 2011	36 MoReg 1735
11-15	Authorizes the Joplin Public School system to immediately rebuild, restore, and/or renovate Emerson Elementary, Kelsey Norman Elementary, Old South Middle School, and Washington Education Center without requiring advertisement for bids	June 1, 2011	36 MoReg 1594
11-14	Activates the state militia in response to a tornado that hit the City of Joplin on May 22, 2011	May 26, 2011	36 MoReg 1592
11-13	Authorizes the Joplin Public Schools system to immediately begin rebuilding and replacing the materials for three of its buildings that were destroyed in a tornado that struck on May 22, 2011, without requiring advertisement for bids	May 26, 2011	36 MoReg 1590
11-12	Orders the director of the Department of Insurance, Financial Institutions and Professional Registration to temporarily waive, suspend, and/or modify any statute or regulation under his purview in order to best serve the interests of those citizens affected by the tornado that hit the city of Joplin on May 22, 2011	May 26, 2011	36 MoReg 1587

Executive Orders	Subject Matter	Filed Date	Publication
11-11	Orders the director of revenue to issue duplicate or replacement license, nondriver license, certificate of motor vehicle ownership, number plate, or tabs lost or destroyed as a result of the tornado that hit the city of Joplin and to waive all state fees and charges for such duplicate or replacement	May 26, 2011	36 MoReg 1585
11-10	Orders the Missouri Department of Health and Senior Services and the State Board of Pharmacy to temporarily waive certain rules and regulations to allow medical practitioners and pharmacists responding to the tornado and severe storms in Joplin to best serve the interests of public health and safety	May 24, 2011	36 MoReg 1583
11-09	Extends Executive Orders 11-06, 11-07, and 11-08 through June 20, 2011	May 20, 2011	36 MoReg 1581
11-08	Activates the state militia in response to severe weather that began on April 22	April 25, 2011	36 MoReg 1449
11-07	Gives the director of the Department of Natural Resources the authority to temporarily suspend regulations in the aftermath of severe weather that began on April 22	April 25, 2011	36 MoReg 1447
11-06	Declares a state of emergency for the state of Missouri and activates the Missouri State Emergency Operations Plan due to severe weather that began on April 22	April 22, 2011	36 MoReg 1445
11-05	Orders the Missouri Department of Transportation to assist local jurisdictions in counties that: 1) received record snowfalls; and 2) continuing snow clearance exceeds their capabilities	Feb. 4, 2011	36 MoReg 883
11-04	Activates the state militia in response to severe weather that began on January 31, 2011	Jan. 31, 2011	36 MoReg 881
11-03	Declares a state of emergency exists in the state of Missouri and directs that the Missouri State Emergency Operations Plan be activated	Jan. 31, 2011	36 MoReg 879
11-02	Extends the declaration of emergency contained in Executive Order 10-27 and the terms of Executive Order 11-01 through February 28, 2011	Jan. 28, 2011	36 MoReg 877
11-01	Gives the Director of the Department of Natural Resources the authority to temporarily suspend regulations in the aftermath of severe winter weather that began on December 30	Jan. 4, 2011	36 MoReg 705

The rule number and the MoReg publication date follow each entry to this index.

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